General Assembly **Bill No. 2051**

September Special Session, 2009

LCO No. **9887**

09887_____

Referred to Committee on No Committee

Introduced by:
SEN. WILLIAMS, 29th Dist.
REP. DONOVAN, 84th Dist.

AN ACT IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING PUBLIC HEALTH AND MAKING CHANGES TO VARIOUS HEALTH STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-612 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established, **[**an**]** within the Department of Public Health, a division to be known as the Office of Health Care Access. **[**The powers of the office shall be vested in and exercised by a commissioner who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive. Said commissioner shall have (1) a graduate degree, and (2) a minimum of ten years' experience in the field of financial management, health insurance, hospital administration or a combination of such experience.**]** The division, under the direction of the Commissioner of Public Health, shall constitute a successor to the former Office of Health Care Access, in accordance with the provisions of sections 4-38d and 4-39.

(b) Any order, decision, agreed settlement, or regulation of the Office of Health Care Access which is in force on the effective date of this section, shall continue in force and effect as an order or regulation of the Department of Public Health until amended, repealed or superseded pursuant to law.

(c) If the words "Office of Health Care Access" are used or referred to in any public or special act of 2009 or in any section of the general statutes which is amended in 2009, such words shall be deemed to mean or refer to the Office of Health Care Access division within the Department of Public Health.

Sec. 2. (NEW) (*Effective from passage*) Notwithstanding any provision of the general statutes, there shall be a Deputy Commissioner of Public Health who shall oversee the Office of Health Care Access division of the Department of Public Health and who shall exercise independent decision-making authority over all certificate of need related matters, including, but not limited to, determinations, orders, decisions and agreed settlements. The individual serving as the Commissioner of Health Care Access on September 1, 2009, shall serve as a Deputy Commissioner of Public Health with responsibility for overseeing the Office of Health Care Access division of the Department of Public Health. Notwithstanding any provision of the general statutes, said deputy commissioner may designate an executive assistant to serve in such capacity. On or before January 1, 2010, said deputy commissioner in consultation with the Commissioner of Public Health shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and joint standing committee of the General Assembly having cognizance of matters related to public health on recommendations for reform of the certificate of need process.

Sec. 3. Section 19a-613 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Office of Health Care Access may employ the most effective and practical means necessary to fulfill the purposes of this chapter,

which may include, but need not be limited to:

(1) Collecting patient-level outpatient data from health care facilities or institutions, as defined in section 19a-630, as amended by this act;

(2) Establishing a cooperative data collection effort, across public and private sectors, to assure that adequate health care personnel demographics are readily available; and

(3) Performing the duties and functions as enumerated in subsection (b) of this section.

(b) The office shall: (1) Authorize and oversee the collection of data required to carry out the provisions of this chapter; (2) oversee and coordinate health system planning for the state; (3) monitor health care costs; and (4) implement and oversee health care reform as enacted by the General Assembly.

(c) The Commissioner of **[**Health Care Access**]** Public Health or any person the commissioner designates may conduct a hearing and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Office of Health Care Access.

Sec. 4. Section 19a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of **[**Health Care Access**]** Public Health may employ and pay professional and support staff subject to the provisions of chapter 67 and contract with and engage consultants and other independent professionals as may be necessary or desirable to carry out the functions of the office.

(b) The commissioner may establish a consumer education unit within the office to provide information to residents of the state concerning the availability of public and private health care coverage.

Sec. 5. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this chapter, unless the context otherwise requires:

(1) "Health care facility or institution" means any facility or institution engaged primarily in providing services for the prevention, diagnosis or treatment of human health conditions, including, but not limited to: Outpatient clinics; outpatient surgical facilities; imaging centers; home health agencies and mobile field hospitals, as defined in section 19a-490; clinical laboratory or central service facilities serving one or more health care facilities, practitioners or institutions; hospitals; nursing homes; rest homes; nonprofit health centers; diagnostic and treatment facilities; rehabilitation facilities; and mental health facilities. "Health care facility or institution" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility or institution, but does not include any health care facility operated by a nonprofit educational institution solely for the students, faculty and staff of such institution and their dependents, or any Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(2) "State health care facility or institution" means a hospital or other such facility or institution operated by the state providing services which are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC Section 301 et seq., as amended.

(3) "Office" means the Office of Health Care Access division of the Department of Public Health.

(4) "Commissioner" means the Commissioner of **[**Health Care Access**]** Public Health.

(5) "Person" has the meaning assigned to it in section 4-166.

Sec. 6. Section 19a-631 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section and section 19a-632, as amended by this act, "hospital" means each hospital subject to the provisions of this chapter and licensed as a short-term acute-care general hospital or a children's hospital or both by the Department of Public Health.

(b) Each hospital shall annually pay to the Commissioner of **[**Health Care Access**]** Public Health, for deposit in the General Fund, an amount equal to its share of the actual expenditures made by the office during each fiscal year including the cost of fringe benefits for office personnel as estimated by the Comptroller, the amount of expenses for central state services attributable to the office for the fiscal year as estimated by the Comptroller, plus the expenditures made on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year. Payments shall be made by assessment of all hospitals of the costs calculated and collected in accordance with the provisions of this section and section 19a-632, as amended by this act. If for any reason a hospital ceases operation, any unpaid assessment for the operations of the office shall be reapportioned among the remaining hospitals to be paid in addition to any other assessment.

Sec. 7. Subsection (b) of section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The costs of the office shall be the total of (1) the amount appropriated for expenses for the operation of the office for the fiscal year, as estimated by the Comptroller, (2) the cost of fringe benefits for office personnel for such year, as estimated by the Comptroller, (3) the amount of expenses for central state services attributable to the office for the fiscal year as estimated by the Comptroller, and (4) the estimated expenditures on behalf of the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, provided for purposes of this calculation the amount **[**so appropriated**]** of expenses for the operation of the office for the fiscal year as

estimated by the Comptroller, plus the cost of fringe benefits for personnel, the amount of expenses for said central state services for the fiscal year as estimated by the Comptroller, and said estimated expenditures from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the office.

Sec. 8. Section 19a-634 of the general statutes, as amended by section 1 of public act 09-77, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Office of Health Care Access shall conduct, on an annual basis, a state-wide health care facility utilization study. Such study shall include, but not be limited to, an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the **[**Commissioner of Health Care Access**]** office deems pertinent to health care facility utilization. Not later than June thirtieth of each year, the **[**commissioner**]** Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the **[**commissioner's**]** office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The office, in consultation with such other state agencies as the Commissioner of **[**Health Care Access**]** Public Health deems appropriate, shall establish and maintain a state-wide health care facilities plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care, and clinic care; (2) an evaluation of the unmet needs of

persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities plan on or before July 1, 2012, and every five years thereafter. Said plan shall be considered part of the state health plan for purposes of office deliberations pursuant to section 19a-637.

Sec. 9. Subsection (b) of section 19a-638 of the general statutes, as amended by section 92 of public act 09-232, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The office shall make such review of a request made pursuant to subdivision (1), (2) or (3) of subsection (a) of this section as it deems necessary. In the case of a health care facility or institution that intends to transfer its ownership or control, the review shall include, but not be limited to, the financial responsibility and business interests of the transferee and the ability of the institution to continue to provide needed services or, in the case of the introduction of a new or additional function or service expansion or the termination of a service or function, ascertaining the availability of such service or function at other inpatient rehabilitation facilities, health care facilities or institutions or state health care facilities or institutions or other

providers within the area to be served, the need for such service or function within such area and any other factors which the office deems relevant to a determination of whether the facility or institution is justified in introducing or terminating such functions or services into or from its program. The office shall grant, modify or deny such request no later than ninety days after the date of receipt of a complete application, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the office has requested additional information subsequent to the commencement of the review period. The commissioner, or the commissioner's designee, may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the office. Failure of the office to act on such request within such review period shall be deemed approval thereof. The ninety-day review period, pursuant to this subsection, for an application filed by a hospital, as defined in section 19a-490, and licensed as a short-term acute-care general hospital or children's hospital by the Department of Public Health or an affiliate of such a hospital or any combination thereof, shall not apply if, in the certificate of need application or request, the hospital or applicant projects either (1) that, for the first three years of operation taken together, the total impact of the proposal on the operating budget of the hospital or an affiliate of such a hospital or any combination thereof will exceed one per cent of the actual operating expenses of the hospital for the most recently completed fiscal year as filed with or determined by the office, or (2) that the total capital expenditure for the project will exceed fifteen million dollars. If the office determines that an application is not subject to the ninety-day review period pursuant to this subsection, it shall remain so excluded for the entire review period of that application, even if the application or circumstances change and the application no longer meets the stated terms of the exclusion. Upon a showing by such facility or institution that the need for such function or service or termination or transfer of its ownership or control is of an emergency nature, in that the function,

service or termination or transfer of its ownership or control is necessary to maintain continued access to the health care services provided by the facility or institution, or to comply with requirements of any federal, state or local health, fire, building or life safety code, the commissioner, or the commissioner's designee, may waive the letter of intent requirement, provided such request shall be submitted not less than fourteen days before the proposed date of institution of the function, service or termination or transfer of its ownership or control.

Sec. 10. Section 19a-639 of the general statutes, as amended by section 93 of public act 09-232, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Except as provided in sections 19a-639a to 19a-639c, inclusive, as amended by **[**this act**]** public act 09-232, each health care facility or institution, including, but not limited to, any inpatient rehabilitation facility, any health care facility or institution or any state health care facility or institution proposing (1) a capital expenditure exceeding three million dollars, (2) to purchase, lease or accept donation of major medical equipment requiring a capital expenditure, as defined in regulations adopted pursuant to section 19a-643, as amended by this act, in excess of three million dollars, or (3) to purchase, lease or accept donation of a CT scanner, PET scanner, PET/CT scanner or MRI scanner, a linear accelerator or other similar equipment utilizing technology that is new or being introduced into this state, including the purchase, lease or donation of equipment or a facility, shall submit a request for approval of such expenditure to the office, with such data, information and plans as the office requires in advance of the proposed initiation date of such project.

(b) (1) The commissioner, or the commissioner's designee, shall notify the Commissioner of Social Services of any certificate of need request that may impact expenditures under the state medical assistance program. The office shall consider such request in relation to the community or regional need for such capital program or purchase

of land, the possible effect on the operating costs of the health care facility or institution and such other relevant factors as the office deems necessary. In approving or modifying such request, the commissioner, or the commissioner's designee, may not prescribe any condition, such as but not limited to, any condition or limitation on the indebtedness of the facility or institution in connection with a bond issue, the principal amount of any bond issue or any other details or particulars related to the financing of such capital expenditure, not directly related to the scope of such capital program and within control of the facility or institution.

(2) An applicant, prior to submitting a certificate of need application, shall submit a request, in writing, for application forms and instructions to the office. The request shall be known as a letter of intent. A letter of intent shall conform to the letter of intent requirements of subdivision (4) of subsection (a) of section 19a-638, as amended by public act 09-232 and this act. No certificate of need application will be considered submitted to the office unless a current letter of intent, specific to the proposal and in compliance with this subsection, is on file with the office for not less than sixty days. A current letter of intent is a letter of intent that has been on file at the office no more than one hundred twenty days, except that an applicant may request a one-time extension of a letter of intent of not more than an additional thirty days for a maximum total of not more than one hundred fifty days if, prior to the expiration of the current letter of intent, the office receives a written request to so extend the letter of intent's current status. The extension request shall fully explain why an extension is requested. The office shall accept or reject the extension request not later than seven days from the date the office receives the extension request and shall so notify the applicant. Upon a showing by such facility or institution that the need for such capital program is of an emergency nature, in that the capital expenditure is necessary to maintain continued access to the health care services provided by the facility or institution, or to comply with any federal, state or local health, fire, building or life safety code, the commissioner, or the

commissioner's designee, may waive the letter of intent requirement, provided such request shall be submitted not less than fourteen days before the proposed initiation date of the project. The commissioner, or the commissioner's designee, shall grant, modify or deny such request not later than ninety days or not later than fourteen days, as the case may be, after receipt of such request, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the office has requested additional information subsequent to the commencement of the review period. The commissioner, or the commissioner's designee, may extend the review period for a maximum of thirty days if the applicant has not filed, in a timely manner, information deemed necessary by the office. Failure of the office to act upon such request within such review period shall be deemed approval of such request. The ninety-day review period, pursuant to this section, for an application filed by a hospital, as defined in section 19a-490, and licensed as a short-term acute care general hospital or a children's hospital by the Department of Public Health or an affiliate of such a hospital or any combination thereof, shall not apply if, in the certificate of need application or request, the hospital or applicant projects either (A) that, for the first three years of operation taken together, the total impact of the proposal on the operating budget of the hospital or an affiliate or any combination thereof will exceed one per cent of the actual operating expenses of the hospital for the most recently completed fiscal year as filed with the office, or (B) that the total capital expenditure for the project will exceed fifteen million dollars. If the office determines that an application is not subject to the ninety-day review period pursuant to this subsection, it shall remain so excluded for the entire period of that application, even if the application or circumstances change and the application no longer meets the stated terms of the exclusion. The **[**office**]** Department of Public Health shall adopt regulations, in accordance with chapter 54, to establish an expedited hearing process to be used to review requests by any facility or institution for approval of a capital expenditure to establish an energy conservation program

or to comply with requirements of any federal, state or local health, fire, building or life safety code or final court order. The **[**office**]** Department of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to provide for the waiver of a hearing for any part of a request by a facility or institution for a capital expenditure, provided such facility or institution and the office agree upon such waiver.

(3) The office shall comply with the public notice provisions of subdivision (4) of subsection (a) of section 19a-638, as amended by public act 09-232 and this act, and shall hold a public hearing with respect to any complete certificate of need application filed under this section, if: (A) The proposal has associated total capital expenditures or total capital costs that exceed twenty million dollars for land, building or nonclinical equipment acquisition, new building construction or building renovation; (B) the proposal has associated total capital expenditures per unit or total capital costs per unit that exceed three million dollars for the purchase, lease or donation acceptance of major medical equipment; (C) the proposal is for the purchase, lease or donation acceptance of equipment utilizing technology that is new or being introduced into the state, including scanning equipment, a linear accelerator or other similar equipment; or (D) three individuals or an individual representing an entity comprised of five or more people submit a request, in writing, that a public hearing be held on the proposal and such request is received by the office not later than twenty-one days after the office deems the certificate of need application complete. At least two weeks' notice of such public hearing shall be given to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the applicant. At the discretion of the office, such hearing shall be held in Hartford or in the area so served or to be served.

(c) Each person or provider, other than a health care or state health care facility or institution subject to subsection (a) of this section, proposing to purchase, lease, accept donation of or replace (1) major

medical equipment with a capital expenditure in excess of three million dollars, or (2) a CT scanner, PET scanner, PET/CT scanner or MRI scanner, a linear accelerator or other similar equipment utilizing technology that is new or being introduced into the state, shall submit a request for approval of any such purchase, lease, donation or replacement pursuant to the provisions of subsection (a) of this section. In determining the capital cost or expenditure for an application under this section or section 19a-638, as amended by public act 09-232 and this act, the office shall use the greater of (A) the fair market value of the equipment as if it were to be used for full-time operation, whether or not the equipment is to be used, shared or rented on a part-time basis, or (B) the total value or estimated value determined by the office of any capitalized lease computed for a three-year period. Each method shall include the costs of any service or financing agreements plus any other cost components or items the office specifies in regulations, adopted in accordance with chapter 54, or deems appropriate.

(d) Notwithstanding the provisions of section 19a-638, as amended by public act 09-232 and this act, or subsection (a) of this section, no community health center, as defined in section 19a-490a, shall be subject to the provisions of said section 19a-638 or subsection (a) of this section if the community health center is: (1) Proposing a capital expenditure not exceeding three million dollars; (2) exclusively providing primary care or dental services; and (3) either (A) financing one-third or more of the cost of the proposed project with moneys provided by the state of Connecticut, (B) receiving funds from the Department of Public Health for the proposed project, or (C) locating the proposed project in an area designated by the federal Health Resources and Services Administration as a health professional shortage area, a medically underserved area or an area with a medically underserved population. Each community health center seeking an exemption under this subsection shall provide the office with documentation verifying to the satisfaction of the office, qualification for this exemption. Each community health center

proposing to provide any service other than a primary care or dental service at any location, including a designated community health center location, shall first obtain a certificate of need for such additional service in accordance with this section and section 19a-638, as amended by public act 09-232 and this act. Each satellite, subsidiary or affiliate of a federally qualified health center, in order to qualify under this exemption, shall: (i) Be part of a federally qualified health center that meets the requirements of this subsection; (ii) exclusively provide primary care or dental services; and (iii) be located in a health professional shortage area or a medically underserved area. If the subsidiary, satellite or affiliate does not so qualify, it shall obtain a certificate of need.

(e) Notwithstanding the provisions of section 19a-638, as amended by public act 09-232 and this act, subsection (a) of section 19a-639a, as amended by **[**this act**]** public act 09-232, or subsection (a) of this section, no school-based health care center shall be subject to the provisions of section 19a-638, as amended by public act 09-232 and this act, or subsection (a) of this section if the center: (1) Is or will be licensed by the Department of Public Health as an outpatient clinic; (2) proposes capital expenditures not exceeding three million dollars and does not exceed such amount; (3) once operational, continues to operate and provide services in accordance with the department's licensing standards for comprehensive school-based health centers; and (4) is or will be located entirely on the property of a functioning school.

(f) In conducting its activities under this section or section 19a-638, as amended by public act 09-232 and this act, or under both sections, the office may hold hearings on applications of a similar nature at the same time.

Sec. 11. Section 19a-639b of the general statutes, as amended by section 95 of public act 09-232, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of **[**Health Care Access**]** Public Health or the commissioner's designee may grant an exemption from the requirements of section 19a-638, as amended by public act 09-232 and this act, or subsection (a) of section 19a-639, as amended by public act 09-232 and this act, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to engage in any activity, other than the termination of a service or a facility, otherwise subject to said section or subsection if:

(1) The nonprofit facility, institution or provider is proposing a capital expenditure of not more than three million dollars and the expenditure does not in fact exceed three million dollars;

(2) The activity meets a specific service need identified by a state agency or department with which the nonprofit facility, institution or provider is currently under contract;

(3) The commissioner, executive director, chairman or chief court administrator of the state agency or department that has identified the specific need confirms, in writing, to the office that (A) the agency or department has identified a specific need with a detailed description of that need and that the agency or department believes that the need continues to exist, (B) the activity in question meets all or part of the identified need and specifies how much of that need the proposal meets, (C) in the case where the activity is the relocation of services, the agency or department has determined that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, (D) in the case where a facility or institution seeks to transfer its ownership or control, that the agency or department has investigated the proposed change and the person or entity requesting the change and has determined that the change would be in the best interests of the state and the patients or clients, and (E) the activity will be cost-effective and well managed; and

(4) In the case where the activity is the relocation of services, the Commissioner of **[**Health Care Access**]** Public Health or the commissioner's designee determines that the needs of the area previously served will continue to be met in a better or satisfactory manner.

(b) The Commissioner of **[**Health Care Access**]** Public Health or the commissioner's designee may grant an exemption from the requirements of section 19a-638, as amended by public act 09-232 and this act, or subsection (a) of section 19a-639, as amended by public act 09-232 and this act, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to terminate a service or a facility, provided (1) the commissioner, executive director, chairperson or chief court administrator of the state agency or department with which the nonprofit facility, institution or provider is currently under contract confirms, in writing, to the office that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, and (2) the **[**Commissioner of Health Care Access**]** commissioner or the commissioner's designee determines that the needs of the area previously served will continue to be met in a better or satisfactory manner.

(c) A nonprofit facility, institution or provider seeking an exemption under this section shall provide the office with any information it needs to determine exemption eligibility. An exemption granted under this section shall be limited to part or all of any services, equipment, expenditures or location directly related to the need or location that the state agency or department has identified.

(d) The office may revoke or modify the scope of the exemption at any time following a public review that allows the state agency or department and the nonprofit facility, institution or provider to address specific, identified, changed conditions or any problems that the state agency, department or the office has identified. A party to any

exemption modification or revocation proceeding and the original requesting agency shall be given at least fourteen calendar days written notice prior to any action by the office and shall be furnished with a copy, if any, of a revocation or modification request or a statement by the office of the problems that have been brought to its attention. If the requesting commissioner, executive director, chairman or chief court administrator or the Commissioner of **[**Health Care Access**]** Public Health certifies that an emergency condition exists, only forty-eight hours written notice shall be required for such modification or revocation action to proceed.

(e) A nonprofit facility, institution or provider that is a psychiatric residential treatment facility, as defined in 42 CFR 483.352, shall not be eligible for any exemption provided for in this section, irrespective of whether or not such facility is under contract with a state agency or department.

Sec. 12. Section 19a-639e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Notwithstanding the provisions of sections 19a-486 to 19a-486h, inclusive, as amended by this act, section 19a-638, as amended by this act, 19a-639 or any other provision of this chapter, the **[**Office of Health Care Access**]** office may refuse to accept as filed or submitted a letter of intent or a certificate of need application from any person or health care facility or institution that failed to submit any required data or information, or has filed any required data or information that is incomplete or not filed in a timely fashion. Prior to any refusal and accompanying moratorium under the provisions of this section, the Commissioner of **[**Health Care Access**]** Public Health shall notify the person or health care facility or institution, in writing, and such notice shall identify the data or information that was not received and the data or information that is incomplete in any respect. Such person or health care facility or institution shall have twenty-one days from the date of mailing the notice to provide the commissioner with the

required data or information. Such refusal and related moratorium on accepting a letter of intent or a certificate of need application may remain in effect, at the discretion of the **[**Commissioner of Health Care Access**]** commissioner, until the office determines that all required data or information has been submitted. The commissioner shall have twenty-one days to notify the person or health care facility or institution submitting the data and information whether or not the letter of intent or certificate of need application is refused. Nothing in this section shall preclude or limit the office from taking any other action authorized by law concerning late, incomplete or inaccurate data submission in addition to such a refusal and accompanying moratorium.

Sec. 13. Section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The **[**office**]** Department of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as amended by this act, and sections 19a-644, as amended by this act, and 19a-645 concerning the submission of data by health care facilities and institutions, including data on dealings between health care facilities and institutions and their affiliates, and, with regard to requests or proposals pursuant to sections 19a-638, as amended by this act, and 19a-639, as amended by this act, by state health care facilities and institutions, the ongoing inspections by the office of operating budgets that have been approved by the health care facilities and institutions, standard reporting forms and standard accounting procedures to be utilized by health care facilities and institutions and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget. All such transfers shall be reported to the office within thirty days of the transfer or transfers.

(b) The **[**office**]** Department of Public Health may adopt such regulations, in accordance with the provisions of chapter 54, as are necessary to implement this chapter.

(c) The regulations adopted by the **[**Office of Health Care Access**]** Department of Public Health concerning requests or proposals pursuant to section 19a-639, as amended by this act, shall include a fee schedule for certificate of need review under section 19a-639, as amended by this act. The fee schedule shall (1) contain a minimum filing fee for all applications under said section 19a-639, (2) be based on a percentage of the requested authorization in addition to the minimum filing fee, and (3) apply to new requests and requests for modification of prior decisions if the modification request has a proposed additional cost of one hundred thousand dollars or more beyond the original authorization amount, or if the modification request aggregated with any other prior modification requests totals one hundred thousand dollars or more. The fee schedule shall be reviewed annually and adjusted as necessary.

Sec. 14. Section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid positions; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (3) the salaries paid to hospital employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations.

(b) The **[**office**]** Department of Public Health shall adopt regulations in accordance with chapter 54 to provide for the collection of data and

information in addition to the annual report required in subsection (a) of this section. Such regulations shall provide for the submission of information about the operations of the following entities: Persons or parent corporations that own or control the health care facility, institution or provider; corporations, including limited liability corporations, in which the health care facility, institution, provider, its parent, any type of affiliate or any combination thereof, owns more than an aggregate of fifty per cent of the stock or, in the case of nonstock corporations, is the sole member; and any partnerships in which the person, health care facility, institution, provider, its parent or an affiliate or any combination thereof, or any combination of health care providers or related persons, owns a greater than fifty per cent interest. For purposes of this section, "affiliate" means any person that directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with any health care facility, institution, provider or person that is regulated in any way under this chapter. A person is deemed controlled by another person if the other person, or one of that other person's affiliates, officers, agents or management employees, acts as a general partner or manager of the person in question.

(c) Each nonprofit short-term acute care general or children's hospital shall include in the annual report required pursuant to subsection (a) of this section a report of all transfers of assets, transfers of operations or changes of control involving its clinical or nonclinical services or functions from such hospital to a person or entity organized or operated for profit.

(d) The Office of Health Care Access shall require each hospital licensed by the Department of Public Health, that is not subject to the provisions of subsection (a) of this section, to report to said office on its operations in the preceding fiscal year by filing copies of the hospital's audited financial statements. Such report shall be due at said office on or before the close of business on the last business day of the fifth month following the month in which a hospital's fiscal year ends.

Sec. 15. Section 19a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Office" means the Office of Health Care Access <u>division of the Department of Public Health</u>;

(2) "Fiscal year" means the hospital fiscal year, as used for purposes of this chapter, consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(3) "Hospital" means any short-term acute care general or children's hospital licensed by the Department of Public Health, including the John Dempsey Hospital of The University of Connecticut Health Center;

(4) "Payer" means any person, legal entity, governmental body or eligible organization that meets the definition of an eligible organization under 42 USC Section 1395mm (b) of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. Payer also includes any legal entity whose membership includes one or more payers and any third-party payer; and

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer.

(b) No hospital shall provide a discount or different rate or method of reimbursement from the filed rates or charges to any payer except as provided in this section.

(c) (1) From April 1, 1994, to June 30, 2002, any payer may directly negotiate for a different rate and method of reimbursement with a hospital provided the charges and payments for the payer are reported

in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement shall be effective until filed with the office.

(2) On and after July 1, 2002, any payer may directly negotiate with a hospital for a different rate or method of reimbursement, or both, provided the charges and payments for the payer are on file at the hospital business office in accordance with this subsection. No discount agreement or agreement for a different rate or method of reimbursement, or both, shall be effective until a complete written agreement between the hospital and the payer is on file at the hospital. Each such agreement shall be available to the office for inspection or submission to the office upon request, for at least three years after the close of the applicable fiscal year.

(3) On and after April 1, 1994, the charges and payments for each payer receiving a discount shall be accumulated by the hospital for each payer and reported as required by the office. The office may require a review by the hospital's independent auditor, at the hospital's expense, to determine compliance with this subsection.

(4) From October 2, 1991, to June 30, 2002, a full written copy of each agreement executed pursuant to this subsection shall be filed with the Office of Health Care Access by each hospital executing such an agreement, no later than ten business days after such agreement is executed. On and after July 1, 2002, a full written copy of each agreement executed pursuant to this subsection shall be on file in the hospital business office within twenty-four hours of execution. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. Agreements filed at the Office of Health Care Access, in accordance with this subsection, shall be considered trade secrets pursuant to subdivision (5) of subsection (b) of section 1-210, except that the office may utilize and distribute data derived from such agreements, including the names of the parties to the agreement, the duration and dates of the agreement and the estimated value of

any discount or alternate rate of payment.

(d) A payer may negotiate with a hospital to obtain a discount on rates or charges for prompt payment.

(e) A payer may also negotiate for and may receive a discount for the provision of the following administrative services: (1) A system which permits the hospital to bill the payer through either a computer-processed or machine-readable or similar billing procedure; (2) a system which enables the hospital to verify coverage of a patient by the payer at the time the service is provided; and (3) a guarantee of payment within the scope of the agreement between the patient and the third-party payer for service to the patient prior to the provision of that service.

(f) No hospital may require a payer to negotiate for another element or any combination of the above elements of a discount, as established in subsections (d) and (e) of this section, in order to negotiate for or obtain a discount for any single element. No hospital may require a payer to negotiate a discount for all patients covered by such payer in order to negotiate a discount for any patient or group of patients covered by such payer.

(g) Any hospital which agrees to provide a discount to a payer under subsection (d) or (e) of this section shall file a copy of the agreement in the hospital's business office and shall provide the same discount to any other payer who agrees to make prompt payment or provide administrative services similar to that contained in the agreement. Each agreement filed shall specify on its face that it was executed and filed pursuant to this subsection. The office shall disallow any agreement which gives a discount pursuant to the terms of subsections (d) and (e) of this section which is in excess of the maximum amount set forth in said subsections. No such agreement shall be contingent on volume or drafted in such a manner as to limit the discount to one or more payers by establishing criteria unique to such payers. Any payer aggrieved under this subsection may petition

the office for an order directing the hospital to provide a similar discount. The **[**office**]** Department of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to carry out the provisions of this subsection.

(h) (1) Nothing in this section shall be construed to require payment by any payer or purchaser, under any program or contract for payment or reimbursement of expenses for health care services, for: (A) Services not covered under such program or contract; or (B) that portion of any charge for services furnished by a hospital that exceeds the amount covered by such program or contract.

(2) Nothing in this section shall be construed to supersede or modify any provision of such program or contract that requires payment of a copayment, deductible or enrollment fee or that imposes any similar requirement.

(i) A hospital which has established a program approved by the office with one or more banks for the purpose of reducing the hospital's bad debt load, may reduce its published charges for that portion of a patient's bill for services which a payer who is a private individual is or may become legally responsible for, after all other insurers or third-party payers have been assessed their full charges provided (1) prior to the rendering of such services, the hospital and the individual payer or parent or guardian or custodian have agreed in writing that after receipt of any insurer or third-party payment paid in accordance with the full hospital charges the remaining payment due from the private individual for such reduced charges shall be made in whole or in part from the balance on deposit in a bank account which has been established by or on behalf of such individual patient, and (2) such payment is made from such account. Nothing in this section shall relieve a patient or legally liable person from being responsible for the full amount of any underpayment of the hospital's authorized charges excluding any discount under this section, by a patient's insurer or any other third-party payer for that insurer's or third-party payer's portion

of the bill. Any reduction in charges granted to an individual or parent or guardian or custodian under this subsection shall be reported to the office as a contractual allowance. For purposes of this section "private individual" shall include a patient's parent, legal guardian or legal custodian but shall not include an insurer or third-party payer.

Sec. 16. Section 19a-653 of the general statutes, as amended by section 97 of public act 09-232, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) Any person or health care facility or institution that owns, operates or is seeking to acquire major medical equipment costing over three million dollars, or scanning equipment, a linear accelerator or other similar equipment utilizing technology that is developed or introduced into the state on or after October 1, 2005, or any person or health care facility or institution that is required to file data or information under any public or special act or under this chapter or sections 19a-486 to 19a-486h, inclusive, as amended by this act, or any regulation adopted or order issued under this chapter or said sections, which fails to so file within prescribed time periods, shall be subject to a civil penalty of up to one thousand dollars a day for each day such information is missing, incomplete or inaccurate. Any civil penalty authorized by this section shall be imposed by the **[**Office of Health Care Access**]** Department of Public Health in accordance with subsections (b) to (e), inclusive, of this section.

(2) If a person or health care facility or institution is unsure whether a certificate of need is required under section 19a-638, as amended by public act 09-232 and this act, or section 19a-639, as amended by public act 09-232 and this act, or under both sections, it shall send a letter to the office describing the project and requesting that the office make such a determination. A person making a request for a determination as to whether a certificate of need, waiver or exemption is required shall provide the office with any information the office requests as part of its determination process.

(b) If the **[**office**]** Department of Public Health has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section, it shall notify the person or health care facility or institution by first-class mail or personal service. The notice shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the amount of the civil penalty or penalties to be imposed; (4) the initial date of the imposition of the penalty; and (5) a statement of the party's right to a hearing.

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the office to request (1) a hearing to contest the imposition of the penalty, or (2) an extension of time to file the required data. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The **[**office**]** Department of Public Health may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

(d) A final order of the **[**office**]** Department of Public Health assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the office pursuant to subsection (c) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, denial or other final decision by the **[**office**]** Department of Public Health.

(e) If any person or health care facility or institution fails to pay any

civil penalty under this section, after the assessment of such penalty has become final the amount of such penalty may be deducted from payments to such person or health care facility or institution from the Medicaid account.

Sec. 17. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this section, sections 19a-662, as amended by this act, 19a-669 to 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672 and 19a-676, unless the context otherwise requires:

(1) "Office" means the Office of Health Care Access division of the Department of Public Health;

(2) "Hospital" means any hospital licensed as a short-term acute care general or children's hospital by the Department of Public Health, including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(4) "Base year" means the fiscal year consisting of a twelve-month period immediately prior to the start of the fiscal year for which a budget is being determined or prepared;

(5) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

(6) "Uncompensated care" means the total amount of charity care and bad debts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which have been approved by, and are on file at, the office;

(7) "Medical assistance" means (A) the programs for medical assistance provided under the state-administered general assistance program or the Medicaid program, including the HUSKY Plan, Part A, or (B) any other state-funded medical assistance program, including the HUSKY Plan, Part B;

(8) "CHAMPUS" or "TriCare" means the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC Section 1072(4), as from time to time amended;

(9) "Primary payer" means the payer responsible for the highest percentage of the charges for a patient's inpatient or outpatient hospital services;

(10) "Case mix index" means the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the resulting products for all diagnosis-related groups;

(11) "Contractual allowances" means the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment;

(12) "Medical assistance underpayment" means the amount calculated by dividing the total net revenue by the total gross revenue, and then multiplying the quotient by the total medical assistance charges, and then subtracting medical assistance payments from the product;

(13) "Other allowances" means the amount of any difference

between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

(14) "Gross revenue" means the total gross patient charges for all patient services provided by a hospital;

(15) "Net revenue" means total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances, plus uncompensated care program disproportionate share hospital payments from the Department of Social Services;

(16) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child.

Sec. 18. Section 19a-662 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Effective for fiscal year 1993 and subsequent fiscal years: (1) The office shall require a hospital which engages in inefficient or inappropriate provision of uncompensated care services to submit to the office a cost reduction plan. The Commissioner of Social Services may prospectively reduce the hospital's disproportionate share payments upon notification by the office that the hospital has failed to submit such a plan or to implement a cost reduction plan approved by the office. (2) The **[**office**]** Department of Public Health shall adopt regulations on admitting, billing and collection procedures. Each hospital shall submit to the office its admission, billing and collection procedures and protocols for approval by the office. In the event that the office finds that these procedures and protocols are inadequate, the office may instruct that they be modified. If a hospital does not modify its procedures and protocols as soon as practicable upon being instructed to do so by the office, or is found by the office to be failing to follow its approved procedures and protocols, the Commissioner of

Social Services may reduce the disproportionate share payments to the hospital until such deficiency is corrected. (3) Effective for fiscal year 1994 and subsequent fiscal years, the office shall not recognize and the Commissioner of Social Services shall not make payments for shortfalls due to unpaid costs associated with admissions which were denied through utilization review or denied due to the hospital's failure to comply with payers' utilization review or claims submission requirements. Nothing in subdivision (3) of this section shall limit the hospital's right to collect from any legally liable person or entity for any services rendered.

Sec. 19. Section 19a-673a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of **[**Health Care Access**]** Public Health shall adopt regulations, in accordance with chapter 54, to establish uniform debt collection standards for hospitals.

Sec. 20. Subsection (d) of section 1-84 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) No public official or state employee or employee of such public official or state employee shall agree to accept, or be a member or employee of a partnership, association, professional corporation or sole proprietorship which partnership, association, professional corporation or sole proprietorship agrees to accept any employment, fee or other thing of value, or portion thereof, for appearing, agreeing to appear, or taking any other action on behalf of another person before the Department of Banking, the Claims Commissioner, the Office of Health Care Access division within the Department of Public Health, the Insurance Department, the office within the Department of Consumer Protection that carries out the duties and responsibilities of sections 30-2 to 30-68m, inclusive, the Department of Motor Vehicles, the State Insurance and Risk Management Board, the Department of Environmental Protection, the Department of Public Utility Control,

the Connecticut Siting Council, the Division of Special Revenue within the Department of Revenue Services, the Gaming Policy Board within the Department of Revenue Services or the Connecticut Real Estate Commission; provided this shall not prohibit any such person from making inquiry for information on behalf of another before any of said commissions or commissioners if no fee or reward is given or promised in consequence thereof. For the purpose of this subsection, partnerships, associations, professional corporations or sole proprietorships refer only to such partnerships, associations, professional corporations or sole proprietorships which have been formed to carry on the business or profession directly relating to the employment, appearing, agreeing to appear or taking of action provided for in this subsection. Nothing in this subsection shall prohibit any employment, appearing, agreeing to appear or taking action before any municipal board, commission or council. Nothing in this subsection shall be construed as applying (1) to the actions of any teaching or research professional employee of a public institution of higher education if such actions are not in violation of any other provision of this chapter, (2) to the actions of any other professional employee of a public institution of higher education if such actions are not compensated and are not in violation of any other provision of this chapter, (3) to any member of a board or commission who receives no compensation other than per diem payments or reimbursement for actual or necessary expenses, or both, incurred in the performance of the member's duties, or (4) to any member or director of a quasi-public agency. Notwithstanding the provisions of this subsection to the contrary, a legislator, an officer of the General Assembly or part-time legislative employee may be or become a member or employee of a firm, partnership, association or professional corporation which represents clients for compensation before agencies listed in this subsection, provided the legislator, officer of the General Assembly or part-time legislative employee shall take no part in any matter involving the agency listed in this subsection and shall not receive compensation from any such matter. Receipt of a previously

established salary, not based on the current or anticipated business of the firm, partnership, association or professional corporation involving the agencies listed in this subsection, shall be permitted.

Sec. 21. Subsection (c) of section 1-84b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of this subsection apply to present or former executive branch public officials or state employees who hold or formerly held positions which involve significant decision-making or supervisory responsibility and are designated as such by the Office of State Ethics in consultation with the agency concerned except that such provisions shall not apply to members or former members of the boards or commissions who serve ex officio, who are required by statute to represent the regulated industry or who are permitted by statute to have a past or present affiliation with the regulated industry. Designation of positions subject to the provisions of this subsection shall be by regulations adopted by the Citizen's Ethics Advisory Board in accordance with chapter 54. As used in this subsection, "agency" means the Office of Health Care Access <u>division within the Department of Public Health</u>, the Connecticut Siting Council, the Department of Banking, the Insurance Department, the Department of Public Safety, the office within the Department of Consumer Protection that carries out the duties and responsibilities of sections 30-2 to 30-68m, inclusive, the Department of Public Utility Control, including the Office of Consumer Counsel, the Division of Special Revenue and the Gaming Policy Board and the term "employment" means professional services or other services rendered as an employee or as an independent contractor.

(1) No public official or state employee, in an executive branch position designated by the Office of State Ethics shall negotiate for, seek or accept employment with any business subject to regulation by his agency.

(2) No former public official or state employee who held such a position in the executive branch shall within one year after leaving an agency, accept employment with a business subject to regulation by that agency.

(3) No business shall employ a present or former public official or state employee in violation of this subsection.

Sec. 22. Subsection (a) of section 1-101aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, "department" means the Department of Developmental Services, the Department of Mental Health and Addiction Services **[**,**]** or the Department of Public Health, **[**or the Office of Health Care Access,**]** and "provider" means any independent contractor or private agency under contract with the department to provide services.

Sec. 23. Section 4-5 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Management and Homeland Security, Commissioner of Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Liquor Control Commission, Commissioner of Mental Health and Addiction Services, Commissioner of Public Safety, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Public

Works, Commissioner of Veterans' Affairs, **[**Commissioner of Health Care Access,**]** Chief Information Officer, the chairperson of the Public Utilities Control Authority, the executive director of the Board of Education and Services for the Blind, the executive director of the Connecticut Commission on Culture and Tourism, the Ombudsman for Property Rights and the executive director of the Office of Military Affairs. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 24. Section 5-198 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The offices and positions filled by the following-described incumbents shall be exempt from the classified service:

(a) All officers and employees of the Judicial Department;

(b) All officers and employees of the Legislative Department;

(c) All officers elected by popular vote;

(d) All agency heads, members of boards and commissions and other officers appointed by the Governor;

(e) All persons designated by name in any special act to hold any state office;

(f) All officers, noncommissioned officers and enlisted men in the military or naval service of the state and under military or naval discipline and control;

(g) (1) All correctional wardens, as provided in section 18-82, and (2) all superintendents of state institutions, the State Librarian, the president of The University of Connecticut and any other commissioner or administrative head of a state department or institution who is appointed by a board or commission responsible by statute for the administration of such department or institution;

(h) The State Historian appointed by the State Library Board;

(i) Deputies to the administrative head of each department or institution designated by statute to act for and perform all of the duties of such administrative head during such administrative head's absence or incapacity;

(j) Executive assistants to each state elective officer and each department head, as defined in section 4-5, as amended by this act, provided each position of executive assistant shall have been created in accordance with section 5-214;

(k) One personal secretary to the administrative head and to each undersecretary or deputy to such head of each department or institution provided any classified employee whose position is affected by this subsection shall retain classified status in such position;

(l) All members of the professional and technical staffs of the constituent units of the state system of higher education, as defined in section 10a-1, of all other state institutions of learning, of the Department of Higher Education, and of the agricultural experiment station at New Haven, professional and managerial employees of the Department of Education and teachers certified by the State Board of Education and employed in teaching positions at state institutions;

(m) Physicians, dentists, student nurses in institutions and other professional specialists who are employed on a part-time basis;

(n) Persons employed to make or conduct a special inquiry, investigation, examination or installation;

(o) Students in educational institutions who are employed on a part-time basis;

(p) Forest fire wardens provided for by section 23-36;

(q) Patients or inmates of state institutions who receive

compensation for services rendered therein;

(r) Employees of the Governor including employees working at the executive office, official executive residence at 990 Prospect Avenue, Hartford and the Washington D.C. office;

(s) Persons filling positions expressly exempted by statute from the classified service;

(t) Librarians employed by the State Board of Education or any constituent unit of the state system of higher education;

(u) Employees in the senior executive service;

(v) All officers and employees of the Division of Criminal Justice;

[(w) One executive assistant to the chairman of the Office of Health Care Access, provided such position shall have been created in accordance with section 5-214;**]**

[(x)**]** (w) Professional employees of the Bureau of Rehabilitation Services in the Department of Social Services;

[(y)**]** (x) Lieutenant colonels in the Division of State Police within the Department of Public Safety appointed on or after June 6, 1990, and majors in the Division of State Police within the Department of Public Safety appointed on or after July 1, 1999;

[(z)**]** (y) The Deputy State Fire Marshal in the Division of Fire, Emergency and Building Services within the Department of Public Safety;

[(aa)**]** (z) The chief administrative officer of the Workers' Compensation Commission;

[(bb)**]** (aa) Employees in the education professions bargaining unit;

[(cc)**]** (bb) Disability policy specialists employed by the Council on

Developmental Disabilities; and

[(dd)**]** (cc) The director for digital media and motion picture activities in the Connecticut Commission on Culture and Tourism.

Sec. 25. Subsection (c) of section 17b-337 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing and select committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Social Services appointed by the Commissioner of Social Services; (5) **[**one member**]** two members from the Department of Public Health appointed by the Commissioner of Public Health, one of whom is from the Office of Health Care Access division of the department; (6) one member from the Department of Economic and Community Development appointed by the Commissioner of Economic and Community Development; (7) **[**one member from the Office of Health Care Access appointed by the Commissioner of Health Care Access; (8)**]** one member from the Department of Developmental Services appointed by the Commissioner of Developmental Services; **[**(9)**]** (8) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; **[**(10)**]** (9) one member from the Department of Transportation appointed by the Commissioner of Transportation; **[**(11)**]** (10) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and **[**(12)**]** (11) the executive director of the Office of Protection and Advocacy for Persons with Disabilities or the executive director's designee. The committee shall convene no later

than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

Sec. 26. Subsection (a) of section 17b-353 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any facility, as defined in subsection (a) of section 17b-352, which proposes (1) a capital expenditure exceeding one million dollars, which increases facility square footage by more than five thousand square feet or five per cent of the existing square footage, whichever is greater, (2) a capital expenditure exceeding two million dollars, or (3) the acquisition of major medical equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of equipment or space, shall submit a request for approval of such expenditure, with such information as the department requires, to the Department of Social Services. Any such facility which proposes to acquire imaging equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of such equipment, shall obtain the approval of the Office of Health Care Access in accordance with section 19a-639, as amended by this act, subsequent to obtaining the approval of the Commissioner of Social Services. Prior to the facility's obtaining the imaging equipment, the Commissioner of **[**the Office of Health Care Access**]** Public Health, after consultation with the Commissioner of Social Services, may elect to perform a joint or simultaneous review with the Department of Social Services.

Sec. 27. Section 19a-2b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health may appear and participate as an intervenor at any hearing or proceeding conducted by **[**the Office of

Health Care Access or**]** any **[**other**]** state agency concerning certificate of need or rate or budget review of any health care facility or institution for the purpose of determining compliance with the state health plan.

Sec. 28. Subsection (a) of section 19a-7b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a Health Care Access Commission, within the legislative department, which shall be comprised of: (1) The Commissioner of Public Health; (2) the Commissioner of Social Services; (3) the Insurance Commissioner; (4) **[**the Commissioner of Health Care Access; (5)**]** three members appointed by the president pro tempore of the Senate, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall represent community health centers and one of whom shall represent mental health services; **[**(6)**]** (5) two members appointed by the majority leader of the Senate, one of whom shall represent commercial insurance companies and one of whom shall represent the disabled; **[**(7)**]** (6) three members appointed by the minority leader of the Senate, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, one of whom shall represent Blue Cross and Blue Shield of Connecticut, Inc. and one of whom shall represent small business; **[**(8)**]** (7) three members appointed by the speaker of the House of Representatives, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to human services, one of whom shall represent consumers and one of whom shall represent labor; **[**(9)**]** (8) two members appointed by the majority leader of the House of Representatives, one of whom shall represent large business and one of whom shall represent children; and **[**(10)**]** (9) three members appointed by the minority leader of the House of Representatives, one

of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, one of whom shall represent hospitals and one of whom shall be a pediatric primary care physician. All members of the commission may be represented by designees.

Sec. 29. Section 19a-7e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Department of Public Health, **[**and the Office of Health Care Access,**]** in consultation with the Department of Social Services, shall establish a three-year demonstration program to improve access to health care for uninsured pregnant women under two hundred fifty per cent of the poverty level. Services to be covered by the program shall include, but not be limited to, the professional services of obstetricians, dental care providers, physician assistants or midwives on the staff of the sponsoring hospital and community-based providers; services of pediatricians for purposes of assistance in delivery and postnatal care; dietary counseling; dental care; substance abuse counseling, and other ancillary services which may include substance abuse treatment and mental health services, as required by the patient's condition, history or circumstances; necessary pharmaceutical and other durable medical equipment during the prenatal period; and postnatal care, as well as preventative and primary care for children up to age six in families in the eligible income level. The program shall encourage the acquisition, sponsorship and extension of existing outreach activities and the activities of mobile, satellite and other outreach units. The Commissioner of Public Health **[**, in consultation with the Commissioner of Health Care Access or his designee,**]** shall issue a request for proposals to Connecticut hospitals. Such request shall require: (1) An interactive relationship between the hospital, community health centers, community-based providers and the healthy start program; (2) provisions for case management; (3) provisions for financial eligibility screening, referrals and enrollment

assistance where appropriate to the medical assistance program, the healthy start program or private insurance; and (4) provisions for a formal liaison function between hospitals, community health centers and other health care providers. The Office of Health Care Access is authorized, through the hospital rate setting process, to fund specific additions to fiscal years 1992 to 1994, inclusive, budgets for hospitals chosen for participation in the program. In requesting additions to their budgets, each hospital shall address specific program elements including adjustments to the hospital's expense base, as well as adjustments to its revenues, in a manner which will produce income sufficient to offset the adjustment in expenses. The office shall insure that the network of hospital providers will serve the greatest number of people, while not exceeding a state-wide cost increase of three million dollars per year. Hospitals participating in the program shall report monthly to the Departments of Public Health and Social Services or their designees and annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services such information as the departments and the committees deem necessary.

Sec. 30. Section 19a-25e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Public Health and The University of Connecticut Health Center may, within available appropriations, develop a Connecticut Health Information Network plan to securely integrate state health and social services data, consistent with state and federal privacy laws, within and across The University of Connecticut Health Center **[**, the Office of Health Care Access**]** and the Departments of Public Health, Developmental Services and Children and Families. Data from other state agencies may be integrated into the network as funding permits and as permissible under federal law.

(b) The Department of Public Health and The Center for Public Health and Health Policy at The University of Connecticut Health

Center shall collaborate with the Departments of Information Technology, Developmental Services, and Children and Families **[**and the Office of Health Care Access**]** to develop the Connecticut Health Information Network plan.

(c) The plan shall: (1) Include research in and describe existing health and human services data; (2) inventory the various health and human services data aggregation initiatives currently underway; (3) include a framework and options for the implementation of a Connecticut Health Information Network, including query functionality to obtain aggregate data on key health indicators within the state; (4) identify and comply with confidentiality, security and privacy standards; and (5) include a detailed cost estimate for implementation and potential sources of funding.

Sec. 31. Subsection (b) of section 19a-123d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Any nursing pool which violates any provision of sections 19a-123 to 19a-123d, inclusive, may be assessed a civil penalty by the court not to exceed three hundred dollars for each offense. Each violation shall be a separate and distinct offense and, in the case of a continuing violation, each day of continuance thereof shall be deemed to be a separate and distinct offense. The Commissioner of Public Health **[**or the Commissioner of Health Care Access**]** may request the Attorney General to bring a civil action in the superior court for the judicial district of Hartford for injunctive relief to restrain any further violation of said sections. The Superior Court shall grant such relief upon notice and hearing.

Sec. 32. Subsection (d) of section 19a-127*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) The advisory committee shall consist of (1) four members who

represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by the Connecticut Association of Not-For-Profit Providers for the Aging; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the Commissioner of Public Health; (11) **[**one member who represents and shall be appointed by the Office of Health Care Access; (12)**]** the Commissioner of Public Health or said commissioner's designee; **[**(13)**]** (12) the Commissioner of Social Services or said commissioner's designee; **[**(14)**]** (13) the Secretary of the Office of Policy and Management or said secretary's designee; **[**(15)**]** (14) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; **[**(16)**]** (15) one member who represents and shall be appointed by the federally designated state peer review organization; and **[**(17)**]** (16) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio

nonvoting members in specialties not represented among voting members. Vacancies shall be filled by the person who makes the appointment under this subsection.

Sec. 33. Section 19a-486 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

For purposes of sections 19a-486 to 19a-486h, inclusive, as amended by this act:

(1) "Nonprofit hospital" means a nonprofit entity licensed as a hospital pursuant to this chapter and any entity affiliated with such a hospital through governance or membership, including, but not limited to, a holding company or subsidiary.

(2) "Purchaser" means a person acquiring any assets of a nonprofit hospital through a transfer.

(3) "Person" means any individual, firm, partnership, corporation, limited liability company, association or other entity.

(4) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business.

(5) "Control" has the meaning assigned to it in section 36b-41.

(6) "Commissioner" means the Commissioner of **[**Health Care Access**]** Public Health or the commissioner's designee.

Sec. 34. Section 19a-486g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health shall refuse to issue a license to, or if issued shall suspend or revoke the license of, a hospital if the commissioner finds, after a hearing and opportunity to be heard, that:

(1) There was a transaction described in section 19a-486a **[**without the approval of the Commissioner of Health Care Access**]** that occurred without the approval of the commissioner, if such approval was required by sections 19a-486 to 19a-486h, inclusive, **[**and the Commissioner of Health Care Access certifies to the Commissioner of Public Health that approval was not obtained**]** as amended by this act;

(2) There was a transaction described in section 19a-486a without the approval of the Attorney General, if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the Attorney General certifies to the Commissioner of Public Health that such transaction involved a material amount of the nonprofit hospital's assets or operations or a change in control of operations; or

(3) The hospital is not complying with the terms of an agreement approved by the Attorney General and commissioner pursuant to sections 19a-486 to 19a-486h, inclusive, as amended by this act.

Sec. 35. Section 19a-486h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by this act, shall be construed to limit: (1) The common law or statutory authority of the Attorney General; (2) the statutory authority of the Commissioner of **[**the Office of Health Care Access or the Commissioner of**]** Public Health including, but not limited to, licensing and certificate of need authority; or (3) the application of the doctrine of cy pres or approximation.

Sec. 36. Subsection (d) of section 19a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) In addition, when the Commissioner of Social Services deems it necessary, said commissioner, or a designated representative of **[**the Commissioner of Social Services, at the request of the Office of Health

Care Access or when the Commissioner of Social Services deems it necessary**]** said commissioner, may examine and audit the financial records of any nursing home facility, as defined in section 19a-521. Each such nursing home facility shall retain all financial information, data and records relating to the operation of the nursing home facility for a period of not less than ten years, and all financial information, data and records relating to any real estate transactions affecting such operation, for a period of not less than twenty-five years, which financial information, data and records shall be made available, upon request, to the Commissioner of Social Services or such designated representative at all reasonable times.

Sec. 37. Subsection (c) of section 38a-676a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) Any working group convened pursuant to subsection (b) of this section shall consist of:

(1) The chairpersons and ranking members, or their designees, of (A) the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary, public health and insurance, and (B) the Legislative Program Review and Investigations Committee;

(2) One member appointed by the Connecticut Medical Society;

(3) One member appointed by the Connecticut Hospital Association;

(4) One member appointed by the Connecticut Trial Lawyers Association;

(5) One representative of a patient advocacy group appointed by the speaker of the House of Representatives;

(6) One representative of a medical malpractice insurer licensed and actively doing business in this state appointed by the president pro

tempore of the Senate;

(7) The Commissioner of **[**the Office of Health Care Access**]** Public Health, or a designee; and

(8) The Insurance Commissioner.

Sec. 38. Subsection (e) of section 38a-1051 of the general statutes, as amended by section 9 of public act 09-232, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) The commission shall: (1) Review and comment on any proposed state legislation and regulations that would affect the health of populations in the state experiencing racial, ethnic, cultural or linguistic disparities in health status, (2) review and comment on the Department of Public Health's health disparities performance measures, (3) advise and provide information to the Governor and the General Assembly on the state's policies concerning the health of populations in the state experiencing racial, ethnic, cultural or linguistic disparities in health status, (4) work as a liaison between populations experiencing racial, ethnic, cultural or linguistic disparities in health status and state agencies in order to eliminate such health disparities, (5) evaluate policies, procedures, activities and resource allocations to eliminate health status disparities among racial, ethnic and linguistic populations in the state and have the authority to convene the directors and commissioners of all state agencies whose purview is relevant to the elimination of health disparities, including but not limited to, the Departments of Public Health, Social Services, Children and Families, Developmental Services, Education, Mental Health and Addiction Services, Labor, Transportation, and the Housing Finance Authority **[**and the Office of Health Care Access**]** for the purpose of advising on and directing the implementation of policies, procedures, activities and resource allocations to eliminate health status disparities among racial, ethnic and linguistic populations in the state, (6) prepare and submit to the Governor and General Assembly an annual report, in accordance with section 11-4a,

that provides both a retrospective and prospective view of health disparities and the state's efforts to ameliorate identifiable disparities among populations of the state experiencing racial, ethnic, cultural or linguistic disparities in health status, (7) explore other successful programs in other sectors and states, and pilot and provide grants for new creative programs that may diminish or contribute to the elimination of health disparities in the state and culturally appropriate health education demonstration projects, for which the commission may apply for, accept and expand public and private funding, (8) have the authority to collect and analyze government and other data regarding the health status of state inhabitants based on race, ethnicity, gender, national origin and linguistic ability, including access, services and outcomes in private and public health care institutions within the state, including, but not limited to, the data collected by the Connecticut Health Information Network, (9) have the authority to draft and recommend proposed legislation, regulations and other policies designed to address disparities in health status, and (10) have the authority to conduct hearings and interviews, and receive testimony, regarding matters pertinent to its mission.

Sec. 39. Section 19a-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[(a) Upon application to the Department of Public Health, each part-time health department shall annually receive from the state an amount equal to forty-nine cents per capita.**]**

[(b)**]** (a) Any municipality may designate itself as having a part-time health department if: (1) The municipality has not had a full-time health department or been in a full-time health district prior to January 1, 1998; (2) the municipality has the equivalent of at least one full-time employee, as determined by the Commissioner of Public Health; (3) the municipality annually submits a public health program plan and budget to the commissioner; and (4) the commissioner approves the program plan and budget.

[(c)**]** (b) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, for the development and approval of the program plan and budget required by subdivision (3) of subsection **[**(b)**]** (a) of this section.

Sec. 40. Section 19a-202 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Upon application to the Department of Public Health any municipal health department shall annually receive from the state an amount equal to one dollar and eighteen cents per capita, provided such municipality (1) employs a full-time director of health, except that if a vacancy exists in the office of director of health or the office is filled by an acting director for more than three months, such municipality shall not be eligible for funding unless the Commissioner of Public Health waives this requirement; (2) submits a public health program and budget which is approved by the Commissioner of Public Health; **[**and**]** (3) appropriates not less than one dollar per capita, from the annual tax receipts, for health department services; and (4) has a population of fifty thousand or more. Such municipal department of health may use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such municipal department of health. The money so received shall be disbursed upon warrants approved by the chief executive officer of such municipality. The Comptroller shall annually in July and upon a voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such municipal department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of such municipal department of health for the ensuing year. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Sec. 41. Section 19a-245 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Upon application to the Department of Public Health, each health district that has a total population of fifty thousand or more, or serves three or more municipalities irrespective of the combined total population of such municipalities, shall annually receive from the state an amount equal to **[**two dollars and forty-three cents**]** one dollar and eighty-five cents per capita for each town, city and borough of such district, **[**which has a population of five thousand or less, and two dollars and eight cents per capita for each town, city and borough of such district which has a population of more than five thousand,**]** provided (1) the Commissioner of Public Health approves the public health program and budget of such health district, and (2) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts. Such district departments of health are authorized to use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The Comptroller shall quarterly, in July, October, January and April, upon such application and upon the voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such district department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Sec. 42. Section 19a-694 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) All managed residential communities operating in the state shall:

(1) Provide a written residency agreement to each resident in accordance with section 19a-700;

(2) Afford residents the ability to access services provided by an assisted living services agency. Such services shall be provided in accordance with a service plan developed in accordance with section 19a-699;

(3) Upon the request of a resident, arrange, in conjunction with the assisted living services agency, for the provision of ancillary medical services on behalf of a resident, including physician and dental services, pharmacy services, restorative physical therapies, podiatry services, hospice care and home health agency services, provided the ancillary medical services are not administered by employees of the managed residential community, unless the resident chooses to receive such services;

(4) Provide a formally established security program for the protection and safety of residents that is designed to protect residents from intruders;

(5) Afford residents the rights and privileges guaranteed under title 47a; and

(6) Comply with the provisions of subsection (c) of section 19-13-D105 of the regulations of Connecticut state agencies. **[**; and**]**

[(7) Be subject to oversight and regulation by the Department of Public Health.**]**

(b) No managed residential community shall control or manage the financial affairs or personal property of any resident.

Sec. 43. Section 2 of public act 09-148 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established the SustiNet Health Partnership board of directors. The board of directors shall consist of **[**nine**]** eleven members, as follows: The Comptroller; the Healthcare Advocate; one appointed by the Governor, who shall be a representative of the nursing or allied health professions; one appointed by the president pro tempore of the Senate, who shall be a primary care physician; one appointed by the speaker of the House of Representatives, who shall be a representative of organized labor; one appointed by the majority leader of the Senate, who shall have expertise in the provision of employee health benefit plans for small businesses; one appointed by the majority leader of the House of Representatives, who shall have expertise in health care economics or health care policy; one appointed by the minority leader of the Senate, who shall have expertise in health information technology; and one appointed by the minority leader of the House of Representatives, who shall have expertise in the actuarial sciences or insurance underwriting; one appointed by the Healthcare Advocate who shall be an individual with expertise in either the reduction of racial, ethnic, cultural and linguistic inequities in health care or multi-cultural competency in the health care workforce; and one appointed by the Comptroller. The Comptroller and the Healthcare Advocate shall serve as the chairpersons of the board of directors.

(b) Initial appointments to the board of directors, other than the board members appointed by the Healthcare Advocate and the Comptroller, shall be made on or before July 15, 2009. In the event that an appointing authority fails to appoint a board member by July 31, 2009, the president pro tempore of the Senate and the speaker of the House of Representatives shall jointly appoint a board member meeting the required specifications on behalf of such appointing authority and such board member shall serve a full term provided that the Healthcare Advocate and the Comptroller shall appoint board members not later than thirty days following the effective date of this section. The presence of not less than **[**five**]** six members shall constitute a quorum for the transaction of business. The initial term for

the board member appointed by the Governor shall be for two years. The initial term for board members appointed by the minority leader of the House of Representatives and the minority leader of the Senate shall be for three years. The initial term for board members appointed by the majority leader of the House of Representatives and the majority leader of the Senate shall be for four years. The initial term for the board members appointed by the speaker of the House of Representatives, **[**and**]** the president pro tempore of the Senate, the Comptroller and the Healthcare Advocate shall be for five years. Terms pursuant to this subdivision shall expire on June thirtieth in accordance with the provisions of this subdivision. Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. Not later than thirty days prior to the expiration of a term as provided for in this subsection, the appointing authority may reappoint the current board member or shall appoint a new member to the board. Other than an initial term, a board member shall serve for a term of five years and until a successor board member is appointed. A member of the board pursuant to this subdivision shall be eligible for reappointment. Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

(c) The SustiNet Health Partnership board of directors shall not be construed to be a department, institution or agency of the state. The staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall provide administrative support to the board of directors.

Sec. 44. Subsection (e) of section 17a-248g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) The commissioner shall establish and periodically revise, in accordance with this section, a schedule of fees based on a sliding scale for early intervention services. The schedule of fees shall consider the

cost of such services relative to the financial resources of the state and the parents or legal guardians of eligible children, provided that on and after the effective date of this section, the commissioner shall (1) charge fees to such parents or legal guardians that are sixty per cent greater than the amount of the fees charged on the date prior to the effective date of this section; and (2) charge fees for all services provided, including those services provided in the first two months following the enrollment of a child in the program. Fees may be charged to any such parent or guardian, regardless of income, and shall be charged to any such parent or guardian with a gross annual family income of forty-five thousand dollars or more, except that no fee may be charged to the parent or guardian of a child who is eligible for Medicaid. The Department of Developmental Services may assign its right to collect fees to a designee or provider participating in the early intervention program and providing services to a recipient in order to assist the provider in obtaining payment for such services. The commissioner may implement procedures for the collection of the schedule of fees while in the process of adopting or amending such criteria in regulation, provided the commissioner prints notice of intention to adopt or amend the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such collection procedures and schedule of fees shall be valid until the time the final regulations or amendments are effective.

Sec. 45. Section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide (1) coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday, and (2) a

maximum benefit of **[**three thousand two**]** six thousand four hundred dollars per child per year and an aggregate benefit of **[**nine thousand six**]** nineteen thousand two hundred dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 46. Section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide (1) coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday, and (2) a maximum benefit of **[**three thousand two**]** six thousand four hundred dollars per child per year and an aggregate benefit of **[**nine thousand six**]** nineteen thousand two hundred dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 47. (NEW) (*Effective from passage*) (a) There is established a Sexual Assault Forensic Examiners Advisory Committee consisting of the following: (1) The Chief Court Administrator, or the Chief Court Administrator's designee; (2) The Chief State's Attorney, or the Chief State's Attorney's designee; (3) the Commissioner of Public Health, or the commissioner's designee; (4) a representative from the Division of Scientific Services, appointed by the Commissioner of Public Safety; (5) a representative from the Division of State Police appointed by the

Commissioner of Public Safety; (6) the Victim Advocate, or the Victim Advocate's designee; (7) the president of the Connecticut Hospital Association, or the president's designee; (8) the president of the Connecticut College of Emergency Physicians, or the president's designee; (9) one member from Connecticut Sexual Assault Crisis Services, Inc., appointed by its board of directors; (10) one member from the Connecticut Police Chiefs Association, appointed by the association; (11) one member from the Connecticut Emergency Nurses Association, appointed by the association; and (12) one member from the Connecticut Chapter of the International Association of Forensic Nurses, appointed by the association.

(b) The committee shall advise the Office of Victim Services on the establishment and implementation of the sexual assault forensic examiners program pursuant to subdivision (18) of subsection (b) of section 54-203 of the general statutes, as amended by this act, and section 48 of this act. The committee shall make specific recommendations concerning: (1) The recruitment of registered nurses, advanced practice registered nurses and physicians to participate in such program; (2) the development of a specialized training course concerning such program for registered nurses, advanced practice registered nurses and physicians who participate in the program; (3) the development of agreements between the Judicial Branch, the Department of Public Health and acute care hospitals relating to the scope of services offered under the program and hospital standards governing the provision of such services; (4) individual case tracking mechanisms; (5) utilization of medically accepted best practices; and (6) the development of quality assurance measures.

(c) The Sexual Assault Forensic Examiners Advisory Committee shall terminate on June 30, 2012.

Sec. 48. (NEW) (*Effective from passage*) (a) As used in this section, "sexual assault forensic examiner" means a registered nurse or advanced practice registered nurse licensed pursuant to chapter 378 of

the general statutes or a physician licensed pursuant to chapter 370 of the general statutes.

(b) A sexual assault forensic examiner may provide immediate care and treatment to a victim of sexual assault who is a patient in an acute care hospital and may collect evidence pertaining to the investigation of any sexual assault in accordance with the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a of the general statutes, as amended by this act. Services provided by a sexual assault forensic examiner shall be: (1) In accordance with the hospital's policies and accreditation standards; and (2) pursuant to a written agreement entered into by the hospital, the Department of Public Health and the Office of Victim Services concerning the hospital's participation in the sexual assault forensic examiners program. Nothing in this section shall be construed as altering the scope of the practice of nursing as set forth in section 20-87a of the general statutes.

Sec. 49. Subsection (b) of section 54-203 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The Office of Victim Services shall have the following powers and duties:

(1) To direct each hospital, whether public or private, to display prominently in its emergency room posters giving notice of the availability of compensation and assistance to victims of crime or their dependents pursuant to sections 54-201 to 54-233, inclusive, and to direct every law enforcement agency of the state to inform victims of crime or their dependents of their rights pursuant to sections 54-201 to 54-233, inclusive;

(2) To request from the office of the state's attorney, state police,

local police departments or any law enforcement agency such investigation and data as will enable the Office of Victim Services to determine if in fact the applicant was a victim of a crime or attempted crime and the extent, if any, to which the victim or claimant was responsible for his own injury;

(3) To request from the Department of Correction, other units of the Judicial Department and the Board of Pardons and Paroles such information as will enable the Office of Victim Services to determine if in fact a person who has requested notification pursuant to section 54-228 was a victim of a crime;

(4) To direct medical examination of victims as a requirement for payment under sections 54-201 to 54-233, inclusive;

(5) To take or cause to be taken affidavits or depositions within or without the state;

(6) To apply for, receive, allocate, disburse and account for grants of funds made available by the United States, by the state, foundations, corporations and other businesses, agencies or individuals to implement a program for victim services which shall assist witnesses and victims of crimes as the Office of Victim Services deems appropriate within the resources available and to coordinate services to victims by state and community-based agencies, with priority given to victims of violent crimes, by (A) assigning, in consultation with the Division of Criminal Justice, such victim advocates as are necessary to provide assistance; (B) administering victim service programs; and (C) awarding grants or purchase of service contracts in accordance with the plan developed under subdivision (15) of this subsection to private nonprofit organizations or local units of government for the direct delivery of services, except that the provision of training and technical assistance of victim service providers and the development and implementation of public education campaigns may be provided by private nonprofit or for-profit organizations or local units of government. Such grants and contracts shall be the predominant

method by which the Office of Victim Services shall develop, implement and operate direct service programs and provide training and technical assistance to victim service providers;

(7) To provide each person who applies for compensation pursuant to section 54-204, within ten days of the date of receipt of such application, with a written list of rights of victims of crime involving personal injury and the programs available in this state to assist such victims. The Office of Victim Services, the state or any agent, employee or officer thereof shall not be liable for the failure to supply such list or any alleged inadequacies of such list. Such list shall include, but not be limited to:

(A) Subject to the provisions of sections 18-81e and 51-286e, the victim shall have the right to be informed concerning the status of his or her case and to be informed of the release from custody of the defendant;

(B) Subject to the provisions of section 54-91c, the victim shall have the right to present a statement of his or her losses, injuries and wishes to the prosecutor and the court prior to the acceptance by the court of a plea of guilty or nolo contendere made pursuant to a plea agreement with the state wherein the defendant pleads to a lesser offense than the offense with which the defendant was originally charged;

(C) Subject to the provisions of section 54-91c, prior to the imposition of sentence upon the defendant, the victim shall have the right to submit a statement to the prosecutor as to the extent of any injuries, financial losses and loss of earnings directly resulting from the crime;

(D) Subject to the provisions of section 54-126a, the victim shall have the right to appear before a panel of the Board of Pardons and Paroles and make a statement as to whether the defendant should be released on parole and any terms or conditions to be imposed upon any such release;

(E) Subject to the provisions of section 54-36a, the victim shall have the right to have any property the victim owns which was seized by police in connection with an arrest to be returned;

(F) Subject to the provisions of sections 54-56e and 54-142c, the victim shall have the right to be notified of the application by the defendant for the pretrial program for accelerated rehabilitation and to obtain from the court information as to whether the criminal prosecution in the case has been dismissed;

(G) Subject to the provisions of section 54-85b, the victim cannot be fired, harassed or otherwise retaliated against by an employer for appearing under a subpoena as a witness in any criminal prosecution;

(H) Subject to the provisions of section 54-86g, the parent or legal guardian of a child twelve years of age or younger who is a victim of child abuse or sexual assault may request special procedural considerations to be taken during the testimony of the child;

(I) Subject to the provisions of section 46b-15, the victim of assault by a spouse or former spouse, family or household member has the right to request the arrest of the offender, request a protective order and apply for a restraining order;

(J) Subject to the provisions of sections 52-146k, 54-86e and 54-86f, the victim of sexual assault or domestic violence can expect certain records to remain confidential;

(8) Within available appropriations, to establish a victim's assistance center which shall provide a victims' rights information clearinghouse which shall be a central repository of information regarding rights of victims of crime and services available to such victims and shall collect and disseminate such information to assist victims;

(9) To provide, not later than January 1, 1994, a victims' notification clearinghouse which shall be a central repository for requests for notification filed pursuant to sections 54-228 and 54-229, and to notify,

on and after January 1, 1994, persons who have filed such a request whenever an inmate has applied for release from a correctional institution or reduction of sentence or review of sentence pursuant to section 54-227 or whenever an inmate is scheduled to be released from a correctional institution and, on and after January 1, 1994, to provide victims of family violence crimes, upon request, information concerning any modification or termination of criminal orders of protection;

(10) To provide a telephone hotline that shall provide information on referrals for various services for victims of crime and their families;

(11) To provide staff services to a state advisory council. The council shall consist of not more than fifteen members to be appointed by the Chief Justice and shall include the Chief Victim Compensation Commissioner and members who represent victim populations, including but not limited to, homicide survivors, family violence victims, sexual assault victims, victims of drunk drivers, and assault and robbery victims, and members who represent the judicial branch and executive branch agencies involved with victims of crime. The members shall serve for terms of four years. Any vacancy in the membership shall be filled by the appointing authority for the balance of the unexpired term. The members shall receive no compensation for their services. The council shall meet at least six times a year. The council shall recommend to the Office of Victim Services program, legislative or other matters which would improve services to victims of crime and develop and coordinate needs assessments for both court-based and community-based victim services. The Chief Justice shall appoint two members to serve as cochairmen. Not later than December fifteenth of each year, the council shall report the results of its findings and activities to the Chief Court Administrator;

(12) To utilize such voluntary and uncompensated services of private individuals, agencies and organizations as may from time to time be offered and needed;

(13) To recommend policies and make recommendations to agencies and officers of the state and local subdivisions of government relative to victims of crime;

(14) To provide support and assistance to state-wide victim services coalitions and groups;

(15) To develop, in coordination with the Department of Social Services, the Department of Public Health, the Office of Policy and Management, the Department of Children and Families and the Division of Criminal Justice, a comprehensive plan to more effectively administer crime victims' compensation and coordinate the delivery of services to crime victims, including the funding of such services. Such plan shall be submitted to the Governor and the General Assembly not later than January 1, 1994;

(16) Within available appropriations to establish a crime victims' information clearinghouse which shall be a central repository for information collected pursuant to subdivision (9) of this subsection and information made available through the criminal justice information system, to provide a toll-free telephone number for access to such information and to develop a plan, in consultation with all agencies required to provide notification to victims, outlining any needed statutory changes, resources and working agreements necessary to make the Office of Victim Services the lead agency for notification of victims, which plan shall be submitted to the General Assembly not later than February 15, 2000;

(17) To provide a training program for judges, prosecutors, police, probation and parole personnel, bail commissioners, officers from the Department of Correction and judicial marshals to inform them of victims' rights and available services; **[**and**]**

(18) To establish a sexual assault forensic examiners program that will train and make available sexual assault forensic examiners to adolescent and adult victims of sexual assault who are patients at

participating acute care hospitals. In order to establish and implement such program, the Office of Victim Services may apply for, receive, allocate, disburse and account for grants of funds made available by the United States, the state, foundations, corporations and other businesses, agencies or individuals; and

[(18)**]** (19) To submit to the joint standing committee of the General Assembly having cognizance of matters relating to victim services, in accordance with the provisions of section 11-4a, on or before January 15, 2000, and biennially thereafter a report of its activities under sections 54-201 to 54-233, inclusive, including, but not limited to, implementation of training activities and mandates. Such report shall include the types of training provided, entities providing training and recipients of training.

Sec. 50. (*Effective from passage*) (a) Notwithstanding sections 1 and 11 of public act 09-3 of the June special session, the amount appropriated to the Department of Developmental Services for Personal Services shall be $304,742,900 for the fiscal year ending June 30, 2010, and shall be $304,572,458 for the fiscal year ending June 30, 2011.

(b) Notwithstanding sections 1 and 11 of public act 09-3 of the June special session, the amount appropriated to the Department of Developmental Services for Voluntary Services shall be $32,692,416 for the fiscal year ending June 30, 2010, and shall be $32,692,416 for the fiscal year ending June 30, 2011.

(c) Notwithstanding sections 1 and 11 of public act 09-3 of the June special session, the amount appropriated to the Department of Developmental Services for Community Residential Services shall be $379,447,857 for the fiscal year ending June 30, 2010, and shall be $390,498,055 for the fiscal year ending June 30, 2011.

Sec. 51. Section 19a-255 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any resident of the state afflicted with tuberculosis in any form, who requires medical care for tuberculosis and who applies for care, shall be received: (1) In a state chronic disease hospital; (2) in a private hospital or clinic; or (3) by a physician or other health care provider without regard to the financial condition of the patient. The cost of care and treatment of such patients shall be computed in accordance with the provisions of sections 17b-122, 17b-124 to 17b-132, inclusive, 17b-136 to 17b-138, inclusive, 17b-194 to 17b-197, inclusive, 17b-222 to 17b-250, inclusive, **[**17b-256,**]** 17b-263, 17b-340 to 17b-350, inclusive, 17b-689b and 17b-743 to 17b-747, inclusive, and section 4-67c. **[**and shall be paid by the state if such cost is deemed appropriate by the Commissioner of Public Health to the treatment of tuberculosis.**]**

(b) The Commissioner of Public Health may consider the availability of third-party sources for the payment of any treatment rendered in accordance with subsection (a) of this section when determining whether to pay for such services. If such patient is (1) a veteran and the tuberculosis or suspected tuberculosis for which the veteran has been hospitalized or treated is a service-connected disability entitling the veteran to medical benefits, or (2) eligible for medical benefits under any workers' compensation law or under any other private or public medical insurance or payment plan, such patient or the patient's obligor shall be liable for the costs of such care to the extent of such available benefits. Such costs shall be determined in the manner prescribed in subsection (a) of section 17b-223.

(c) The Department of Social Services and the Department of Public Health may exchange patient information in the possession of said departments for the purpose of determining eligibility for benefits under Title XIX of the Social Security Act for any patient in need of treatment or who has received treatment.

Sec. 52. Section 54-102aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this part:

(1) "Active tuberculosis" shall have the same meaning as provided in subdivision (1) of subsection (a) of section 19a-265;

(2) "Infectious tuberculosis" shall have the same meaning as provided in subdivision (2) of subsection (a) of section 19a-265; and

(3) "Latent tuberculosis" means having a positive tuberculin skin test with no clinical, bacteriologic or radiologic evidence of active tuberculosis.

(b) Any person who has been committed to the custody of the Commissioner of Correction and remains in custody for a period of at least five consecutive days shall be tested to determine if such person has active tuberculosis or latent tuberculosis infection. Any person testing positive for active tuberculosis or infectious tuberculosis shall be subject to the provisions of sections 19a-255 **[**, 19a-256**]** and 19a-262 to 19a-265, inclusive. Any person testing positive for latent tuberculosis infection shall be first medically evaluated for infectious tuberculosis and then offered treatment for latent tuberculosis infection as recommended at the time by the National Centers for Disease Control and Prevention, provided the scheduled period of custody of such person is such that the treatment may be completed prior to the release of such person from custody.

Sec. 53. Section 17b-492c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Mental Heath and Addiction Services, or the commissioner's designee, may be the authorized representative of an applicant or recipient of services provided by the Department of Mental Health and Addiction Services for the purpose of submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner, or the commissioner's designee, may also sign required

forms and enroll the applicant or recipient in a Medicare Part D plan on the applicant's or recipient's behalf. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the department shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner, or the commissioner's designee, as such applicant's or recipient's authorized representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.

(b) Notwithstanding the provisions of section 4a-12, the Commissioner of Mental Health and Addiction Services, after consultation with the Commissioner of Administrative Services, may (1) bill or enter into a contract with a private entity to bill for prescriptions under the Medicare Part D program, and (2) enter into agreements and other contractual arrangements, including negotiated reimbursement rates for Medicare Part D plans, for the support of persons aided, cared for or treated by the Department of Mental Health and Addiction Services.

Sec. 54. Section 54-56g of the general statutes, as amended by section 14 of public act 09-140, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) There shall be a pretrial alcohol education **[**system**]** program for persons charged with a violation of section 14-227a, 14-227g, 15-133, as amended by **[**this act**]** public act 09-140, 15-140*l*, as amended by **[**this act**]** public act 09-140, 15-140n or section 1 of **[**this act**]** public act 09-140. Upon application by any such person for participation in such system and payment to the court of an application fee of **[**fifty**]** one hundred dollars and a nonrefundable evaluation fee of one hundred

dollars, the court shall, but only as to the public, order the court file sealed, provided such person states under oath, in open court or before any person designated by the clerk and duly authorized to administer oaths, under penalties of perjury that: (1) If such person is charged with a violation of section 14-227a, such person has not had such system invoked in such person's behalf within the preceding ten years for a violation of section 14-227a, (2) if such person is charged with a violation of section 14-227g, such person has never had such system invoked in such person's behalf for a violation of section 14-227a or 14-227g, (3) such person has not been convicted of a violation of section 53a-56b or 53a-60d, a violation of subsection (a) of section 14-227a before or after October 1, 1981, or a violation of subdivision (1) or (2) of subsection (a) of section 14-227a on or after October 1, 1985, and (4) such person has not been convicted in any other state at any time of an offense the essential elements of which are substantially the same as section 53a-56b or 53a-60d or subdivision (1) or (2) of subsection (a) of section 14-227a. Unless good cause is shown, a person shall be ineligible for participation in such pretrial alcohol education system if such person's alleged violation of section 14-227a or 14-227g caused the serious physical injury, as defined in section 53a-3, of another person. The application fee imposed by this subsection shall be credited to the Criminal Injuries Compensation Fund established by section 54-215. <u>The evaluation fee shall be credited to the pretrial account established under section 54-56k.</u>

(b) The court, after consideration of the recommendation of the state's attorney, assistant state's attorney or deputy assistant state's attorney in charge of the case, may, in its discretion, grant such application. If the court grants such application, the court shall refer such person to the Court Support Services Division for assessment and confirmation of the eligibility of the applicant and to the Department of Mental Health and Addiction Services for evaluation. The Court Support Services Division, in making its assessment and confirmation, may rely on the representations made by the applicant under oath in open court with respect to convictions in other states of offenses

specified in subsection (a) of this section. Upon confirmation of eligibility and receipt of the evaluation report, the defendant shall be referred to the Department of Mental Health and Addiction Services by the Court Support Services Division for placement in an appropriate alcohol intervention program for one year, or be placed in a state-licensed substance abuse treatment program. The alcohol intervention program shall include a ten-session intervention program and a fifteen-session intervention program. Any person who enters the system shall agree: (1) To the tolling of the statute of limitations with respect to such crime, (2) to a waiver of such person's right to a speedy trial, (3) to complete ten or fifteen counseling sessions in an alcohol intervention program or successfully complete a substance abuse treatment program of not less than twelve sessions pursuant to this section dependent upon the evaluation report and the court order, (4) to commence participation in an alcohol intervention program or substance abuse treatment program not later than ninety days after the date of entry of the court order unless granted a delayed entry into a program by the court, (5) upon completion of participation in the alcohol intervention program, to accept placement in a treatment program upon recommendation of a provider under contract with the Department of Mental Health and Addiction Services pursuant to subsection **[**(d)**]** (f) of this section or placement in a state-licensed treatment program which meets standards established by the Department of Mental Health and Addiction Services, if the Court Support Services Division deems it appropriate, and **[**(5)**]** (6) if ordered by the court, to participate in at least one victim impact panel. The suspension of the motor vehicle operator's license of any such person pursuant to section 14-227b shall be effective during the period such person is participating in such program, provided such person shall have the option of not commencing the participation in such program until the period of such suspension is completed. If the Court Support Services Division informs the court that the defendant is ineligible for the system and the court makes a determination of ineligibility or if the program provider certifies to the court that the defendant did not

successfully complete the assigned program or is no longer amenable to treatment and such person does not pursue, or the court denies, program reinstatement under subsection (e) of this section, the court shall order the court file to be unsealed, enter a plea of not guilty for such defendant and immediately place the case on the trial list. If such defendant satisfactorily completes the assigned program, such defendant may apply for dismissal of the charges against such defendant and the court, on reviewing the record of the defendant's participation in such program submitted by the Court Support Services Division and on finding such satisfactory completion, shall dismiss the charges. If the defendant does not apply for dismissal of the charges against such defendant after satisfactorily completing the assigned program the court, upon receipt of the record of the defendant's participation in such program submitted by the Court Support Services Division, may on its own motion make a finding of such satisfactory completion and dismiss the charges. Upon motion of the defendant and a showing of good cause, the court may extend the one-year placement period for a reasonable period for the defendant to complete the assigned program. A record of participation in such program shall be retained by the Court Support Services Division for a period of seven years from the date of application. The Court Support Services Division shall transmit to the Department of Motor Vehicles a record of participation in such program for each person who satisfactorily completes such program. The Department of Motor Vehicles shall maintain for a period of **[**seven**]** ten years the record of a person's participation in such program as part of such person's driving record. The Court Support Services Division shall transmit to the Department of Environmental Protection the record of participation of any person who satisfactorily completes such program who has been charged with a violation of the provisions of section 15-133, as amended by **[**this act**]** public act 09-140, 15-140*l*, as amended by **[**this act**]** public act 09-140, 15-140n or section 1 of **[**this act**]** public act 09-140. The Department of Environmental Protection shall maintain for a period of **[**seven**]** ten years the record of a person's participation in

such program as a part of such person's boater certification record.

(c) At the time the court grants the application for participation in the alcohol intervention program, such person shall also pay to the court a nonrefundable program fee of three hundred **[**twenty-five**]** fifty dollars if such person is ordered to participate in the ten-session program and a nonrefundable program fee of five hundred dollars if such person is ordered to participate in the fifteen-session program. If the court grants participation in a treatment program, such person shall be responsible for the costs associated with participation in such program. No person may be excluded from either program for inability to pay such fee or cost, provided (1) such person files with the court an affidavit of indigency or inability to pay, (2) such indigency or inability to pay is confirmed by the Court Support Services Division, and (3) the court enters a finding thereof. If the court finds that a person is indigent or unable to pay for a treatment program, the costs of such program shall be paid for from the pretrial account established under section 54-56k. If the court denies the application, such person shall not be required to pay the program fee. If the court grants the application, and such person is later determined to be ineligible for participation in such pretrial alcohol education system or fails to complete the assigned program, the program fee shall not be refunded. All **[**such evaluation and**]** program fees shall be credited to the pretrial account established under section 54-56k.

(d) If a person returns to court with certification from a program provider that such person did not successfully complete the assigned program or is no longer amenable to treatment, the provider, to the extent practicable, shall include a recommendation to the court as to whether a ten-session intervention program, a fifteen-session program or placement in a state-licensed alcohol treatment program would best serve such person's needs. The provider shall also indicate whether the current program referral was an initial referral or a reinstatement to the program.

(e) When a person subsequently requests reinstatement into an intervention or treatment program and the Court Support Services Division verifies that such person is eligible for reinstatement into such program and thereafter the court favorably acts on such request, such person shall pay a nonrefundable fee of one hundred seventy-five dollars if ordered to complete a ten-session intervention program or two hundred fifty dollars if ordered to complete a fifteen-session intervention program, as the case may be. Unless good cause is shown, such fees shall not be waived. If the court grants a person's request to be reinstated into a treatment program, such person shall be responsible for the costs, if any, associated with being reinstated into the treatment program. All fees collected in connection with a reinstatement to an intervention program shall be credited to the pretrial account established under 54-56k. No person shall be permitted more than two program reinstatements pursuant to this subsection.

[(d)**]** (f) The Department of Mental Health and Addiction Services shall contract with service providers, develop standards and oversee appropriate alcohol programs to meet the requirements of this section. Said department shall adopt regulations in accordance with chapter 54 to establish standards for such alcohol programs. Any person ordered to participate in a treatment program shall do so at a state-licensed treatment program which meets the standards established by said department. Any defendant whose employment or residence makes it unreasonable to attend an alcohol intervention program or a treatment program in this state may attend a program in another state which has standards substantially similar to, or higher than, those of this state, subject to the approval of the court and payment of the application, evaluation and program fees, as appropriate, as provided in this section.

[(e)**]** (g) The court may, as a condition of granting such application, require that such person participate in a victim impact panel program approved by the Court Support Services Division of the Judicial

Department. Such victim impact panel program shall provide a nonconfrontational forum for the victims of alcohol-related or drug-related offenses and offenders to share experiences on the impact of alcohol-related or drug-related incidents in their lives. Such victim impact panel program shall be conducted by a nonprofit organization that advocates on behalf of victims of accidents caused by persons who operated a motor vehicle while under the influence of intoxicating liquor or any drug, or both. Such organization may assess a participation fee of not more than seventy-five dollars on any person required by the court to participate in such program, provided such organization shall offer a hardship waiver when it has determined that the imposition of a fee would pose an economic hardship for such person.

[(f)**]** (h) The provisions of this section shall not be applicable in the case of any person charged with a violation of section 14-227a while operating a commercial motor vehicle, as defined in section 14-1.

Sec. 55. Section 54-56i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2010*):

(a) **[**Not later than January 1, 1998, the Department of Mental Health and Addiction Services shall establish**]** There is established a pretrial drug education program for persons charged with a violation of section 21a-267 or 21a-279. The drug education program shall include a ten-session drug intervention program, a fifteen-session drug intervention program and a drug treatment program.

(b) Upon application by any such person for participation in such program and payment to the court of an application fee of one hundred dollars and a nonrefundable evaluation fee of one hundred dollars, the court shall, but only as to the public, order the court file sealed provided such person states under oath, in open court or before any person designated by the clerk and duly authorized to administer oaths, under penalties of perjury, that such person has never had such program invoked in such person's behalf. A person shall be ineligible

for participation in such pretrial drug education program if such person has previously participated in the eight-session, ten-session or fifteen-session drug education program, or substance abuse treatment established under this section or the pretrial community service labor program established under section 53a-39c. The evaluation and application fee required pursuant to this subsection shall be credited to the pretrial account established under section 54-56k.

(c) The court, after consideration of the recommendation of the state's attorney, assistant state's attorney or deputy assistant state's attorney in charge of the case, may, in its discretion, grant such application. If the court grants such application, **[**it**]** the court shall refer such person to the Court Support Services Division for confirmation of the eligibility of the applicant and to the Department of Mental Health and Addiction Services for evaluation.

(d) Upon confirmation of eligibility and receipt of the evaluation required pursuant to subsection (c), such person shall be referred to the Department of Mental Health and Addiction Services by the Court Support Services Division for placement in the drug education program. Participants in the drug education program shall receive appropriate drug intervention services or substance abuse treatment program services, as recommended by the evaluation conducted pursuant to subsection (c) of this section, and ordered by the court. Placement in the drug education program pursuant to this section shall not exceed one year. Persons receiving substance abuse treatment program services in accordance with the provisions of this section shall only receive such services at state licensed substance abuse treatment program facilities that are in compliance with all state standards governing the operation of such facilities. Any person who enters the program shall agree: (1) To the tolling of the statute of limitations with respect to such crime; (2) to a waiver of such person's right to a speedy trial; (3) **[**to any conditions that may be established by the department concerning participation in the drug education program including conditions concerning participation in meetings or sessions of the

program**]** to complete participation in the ten-session drug intervention program, fifteen-session drug intervention program or substance abuse treatment program, as recommended by the evaluation conducted pursuant to subsection (c) of this section, and ordered by the court; (4) to commence participation in the drug education program not later than ninety days after the date of entry of the court order unless granted a delayed entry into the program by the court; and **[**(4)**]** (5) upon completion of participation in the pretrial drug education program, to accept placement in a treatment program upon the recommendation of a provider under contract with the Department of Mental Health and Addiction Services or placement in a treatment program that has standards substantially similar to, or higher than, a program of a provider under contract with the Department of Mental Health and Addiction Services if the Court Support Services Division deems it appropriate. The department shall require as a condition of **[**the assigned program, that such person participate in, and successfully complete, a community service labor program established under section 53a-39c for a period of four days**]** participation in the drug education program that any person participating in the ten-session drug intervention program or the substance abuse treatment program also participate in the community service labor program, established pursuant to section 53a-39c, for not less than five days; and that any person participating in the fifteen-session drug intervention program also participate in said community service labor program, for not less than ten days.

(e) If the Court Support Services Division informs the court that such person is ineligible for the program and the court makes a determination of ineligibility or if the program provider certifies to the court that such person did not successfully complete the assigned program and such person did not pursue or the court denied reinstatement in the program under subsection (i) of this section, the court shall order the court file to be unsealed, enter a plea of not guilty for such person and immediately place the case on the trial list.

(f) If such person satisfactorily completes the assigned program, such person may apply for dismissal of the charges against such person and the court, on reviewing the record of such person's participation in such program submitted by the Court Support Services Division and on finding such satisfactory completion, shall dismiss the charges. If such person does not apply for dismissal of the charges against such person after satisfactorily completing the assigned program, the court, upon receipt of the record of such person's participation in such program submitted by the Court Support Services Division, may on its own motion make a finding of such satisfactory completion and dismiss the charges. Upon motion of such person and a showing of good cause, the court may extend the placement period for a reasonable period for such person to complete the assigned program. A record of participation in such program shall be retained by the Court Support Services Division for a period of **[**seven**]** ten years from the date of application.

(g) At the time the court grants the application for participation in the pretrial drug education program, such person shall pay to the court a nonrefundable program fee of three hundred fifty dollars **[,** except that no**]** if such person is ordered to participate in the ten-session drug intervention program or five hundred dollars if such person is ordered to participate in the fifteen-session drug intervention. If the court orders participation in a drug treatment program, such person shall be responsible for the costs associated with such program. No person may be excluded from any such program for inability to pay such fee, provided (1) such person files with the court an affidavit of indigency or inability to pay, (2) such indigency or inability to pay is confirmed by the Court Support Services Division, and (3) the court enters a finding thereof. The court may waive all or any portion of such fee depending on such person's ability to pay. If the court denies the application, such person shall not be required to pay the program fee. If the court grants the application, and such person is later determined to be ineligible for participation in such pretrial drug education program or fails to complete the assigned program, the **[**three-

hundred-fifty-dollar**]** program **[**fee**]** fees shall not be refunded. All such program fees shall be credited to the pretrial account established under section 54-56k.

(h) If a person returns to court with certification from a program provider that such person did not successfully complete the assigned program or is no longer amenable to treatment, the provider, to the extent practicable, shall include a recommendation to the court as to whether a ten-session drug intervention program, a fifteen-session drug program or placement in a substance abuse treatment program would best serve such person's needs. The provider shall also indicate whether the current program referral was an initial referral or a reinstatement to the program.

(i) When a person subsequently requests reinstatement into a drug intervention program or a substance abuse treatment program and the Court Support Services Division verifies that such person is eligible for reinstatement into such program and thereafter the court favorably acts on such request, such person shall pay a nonrefundable fee of one hundred seventy-five dollars if ordered to complete a ten-session drug intervention program or two hundred fifty dollars if ordered to complete a fifteen-session drug intervention program, as the case may be. Unless good cause is shown, such fees shall not be waived. If the court grants a person's request to be reinstated into a drug treatment program, such person shall be responsible for the costs, if any, associated with being reinstated into the treatment program. All fees collected in connection with a reinstatement to a drug intervention program shall be credited to the pretrial account established under section 54-56k. No person shall be permitted more than two program reinstatements pursuant to this subsection.

[(h)**]** (j) The Department of Mental Health and Addiction Services shall develop standards and oversee appropriate drug education programs to meet the requirements of this section and may contract with service providers to provide such programs. The department

shall adopt regulations, in accordance with chapter 54, to establish standards for such drug education programs.

[(i)**]** (k) Any person whose employment or residence or schooling makes it unreasonable to attend a drug intervention program or substance abuse treatment program in this state may attend a program in another state that has standards similar to, or higher than, those of this state, subject to the approval of the court and payment of the program fee as provided in this section.

Sec. 56. (NEW) (*Effective from passage*) The Commissioner of Mental Health and Addiction Services and the Commissioner of Social Services shall enter into a memorandum of understanding that provides for the Department of Mental Health and Addiction Services to continue to manage the behavioral health managed care program for recipients of medical assistance under the state-administered general assistance program.

Sec. 57. (*Effective from passage*) (a) There is established an advisory committee for reimbursements for services under programs administered by the Department of Developmental Services. The advisory committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and public health; (2) the chairpersons and ranking members of the health subcommittee of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations; (3) one member who is the Governor's designee; (4) the Commissioner of Developmental Services, or the commissioner's designee; (5) one member from the Office of Policy and Management, appointed by the Secretary of the Office of Policy and Management; (6) one member from the Medicaid unit of the Department of Social Services, who has oversight over developmental services reimbursements, appointed by the Commissioner of Social Services; (7) the chief executive officer of the Connecticut Community

Providers Association, or the chief executive officer's designee; (8) the executive director of the Connecticut Association of Nonprofits, or the executive director's designee; (9) the executive director of the ARC of Connecticut, or the executive director's designee; (10) one member who is a chief financial officer from a community provider organization, appointed by the executive director of the Connecticut Community Providers Association; (11) one member who is an information technology officer from a community provider organization, appointed by the executive director of the Connecticut Association of Nonprofits; (12) one member appointed by the president of the labor organization that represents the majority of the workers who perform the services pursuant to these programs; (13) one member who is an employee of the Department of Developmental Services operations staff, appointed by the Commissioner of Developmental Services; (14) one member who is an employee of the Department of Developmental Services information technology staff, appointed by the Commissioner of Developmental Services; and (15) one member who is an employee of the Department of Developmental Services audit unit staff, appointed by the Commissioner of Developmental Services.

(b) The advisory committee shall study the impact of a shift from master contracts to attendance-based, fee-for-service reimbursement in programs administered by the Department of Developmental Services. Such study shall include, but not be limited to, the following: (1) Methodologies that ensure that providers continue to receive reimbursements through the existing system while analysis of an attendance-based, fee-for-service reimbursement program is studied; (2) participation by a large and diverse group of providers based upon such providers' reimbursement rates and attendance rates; (3) review of the appropriateness of the level of need tool, the process for completing level of need tools, level of need scores, the methodology for linking levels of needs to funding and the process for appealing a level of need score; (4) review of the appropriateness of the current reimbursement rates; (5) identification of the costs to move lower wage

providers to a standard wage rate while at the same time holding harmless the higher wage providers; (6) analysis of attendance factors based upon the health of clients and staff vacation time, holidays, personal time off and paid time off; (7) identification of a reasonable attendance factor that would keep providers whole and maintain philosophies of normalization and integration; (8) determination of the appropriate reimbursement models for transportation; (9) review of billing systems and documentation systems to identify information technology hardware and software and related costs; (10) identification of mechanisms to maintain appropriate cash flow to providers; (11) identification of mechanisms for increasing rates in a systematic way to keep pace with growing costs of services; and (12) examination of efficiencies in the service delivery system for people with developmental disabilities.

(c) All appointments to the advisory committee shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the advisory committee, from among the members of said committee. Such chairpersons shall schedule the first meeting of said committee, which shall be held no later than sixty days after the effective date of this section.

(e) The administrative staff of the Department of Developmental Services shall serve as administrative staff of the advisory committee.

(f) Not later than January 1, 2011, the advisory committee shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and public health in accordance with the provisions of section 11-4a of the general statutes. The advisory committee shall terminate on the date that it submits such report or January 1, 2011,

whichever is later.

Sec. 58. (NEW) (*Effective from passage*) (a) Notwithstanding any provision of the general statutes or any regulation adopted thereunder, peer review materials or information produced in conformance with section 19a-17b of the general statutes, in any format or media, shall not be subject to disclosure pursuant to the Freedom of Information Act.

(b) The provisions of subsection (a) of this section shall not preclude the Department of Public Health from accessing such peer review materials or information in connection with any investigation or review by the department regarding the license of a health care provider, as defined in subsection (a) of section 19a-17b of the general statutes, provided the department does not disclose such materials or information to any person outside of the department, except as may be necessary to take disciplinary action against such health care provider, and any such materials or information shall be exempt from disclosure under the Freedom of Information Act.

(c) The provisions of this section shall not limit the protections afforded pursuant to section 19a-17b of the general statutes.

Sec. 59. Subsection (b) of section 3 of public act 09-148 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The SustiNet Health Partnership board of directors shall offer recommendations to the General Assembly on the governance structure of the entity that is best suited to provide oversight and implementation of the SustiNet Plan. Such recommendations may include, but need not be limited to, the establishment of a public authority authorized and empowered:

(1) To adopt guidelines, policies and regulations in accordance with chapter 54 of the general statutes that are necessary to implement the provisions of sections 1 to 14, inclusive, of this act;

(2) To contract with insurers or other entities for administrative purposes, such as claims processing and credentialing of providers. Such contracts shall reimburse these entities using "per capita" fees or other methods that do not create incentives to deny care. The selection of such insurers or other entities may take into account their capacity and willingness to (A) offer timely networks of participating providers both within and outside the state, and (B) help finance the administrative costs involved in the establishment and initial operation of the SustiNet Plan;

(3) To solicit bids from individual providers and provider organizations and to arrange with insurers and others for access to existing or new provider networks, and take such other steps to provide all SustiNet Plan members with access to timely, high-quality care throughout the state and, in appropriate cases, care that is outside the state's borders;

(4) To establish appropriate deductibles, standard benefit packages and out-of-pocket cost-sharing levels for different providers, that may vary based on quality, cost, provider agreement to refrain from balance billing SustiNet Plan members, and other factors relevant to patient care and financial sustainability;

(5) To commission surveys of consumers, employers and providers on issues related to health care and health care coverage;

(6) To negotiate on behalf of providers participating in the SustiNet Plan to obtain discounted prices for vaccines and other health care goods and services;

(7) To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under its enabling legislation, including contracts and agreements for such professional services as financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, bio-ethicists and such

other independent professionals or employees as the board of directors shall deem necessary;

(8) To purchase reinsurance or stop loss coverage, to set aside reserves, or to take other prudent steps that avoid excess exposure to risk in the administration of a self-insured plan;

(9) To enter into interagency agreements for performance of SustiNet Plan duties that may be implemented more efficiently or effectively by an existing state agency;

(10) To set payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote access to care and patient health, prevent unnecessary spending, and ensure sufficient compensation to cover the reasonable cost of furnishing necessary care;

(11) To appoint such advisory committees as may be deemed necessary for the public authority to successfully implement the SustiNet Plan, further the objectives of the public authority and secure necessary input from various experts and stakeholder groups;

(12) To establish and maintain an Internet web site that provides for timely posting of all public notices issued by the public authority or the board of directors and such other information as the public authority or board deems relevant in educating the public about the SustiNet Plan;

(13) To evaluate the implementation of an individual mandate in concert with guaranteed issue, the elimination of preexisting condition exclusions, and the implementation of auto-enrollment;

(14) To <u>apply for and receive federal funds and</u> raise funds from private and public sources outside of the state budget to contribute toward support of its mission and operations;

(15) To make optimum use of opportunities created by the federal

government for securing new and increased federal funding, including, but not limited to, increased reimbursement revenues;

(16) In the event of the enactment of federal health care reform, to submit preliminary recommendations for the implementation of the SustiNet Plan to the General Assembly not later than sixty days after the date of enactment of such federal health care reform; and

(17) To study the feasibility of funding premium subsidies for individuals with income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level.

Sec. 60. Section 10a-256 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is created, as a separate trust fund of the corporation, a Hospital Insurance Fund to be held by the State Treasurer. To this fund shall be charged all payments required to satisfy claims against the hospital and the corporation arising from health care services including (1) claims against the hospital's officers, agents, employees, physicians enjoying privileges at the hospital or at the school of medicine or dental medicine or persons otherwise implementing the purposes of the hospital, (2) all direct expenses and payments for the protection of the interests of the hospital or the state in connection with protection against any of the foregoing, including the payment of insurance premiums and the settlement of claims, and (3) all operating expenses of the corporation, including the cost of professional services, which are attributable to the administration or maintenance of the fund. To the fund shall be credited all receipts of the corporation from contracts for insurance with the hospital or the state as provided under subsection (b) of section 10a-255 and such other moneys of the corporation as the corporation deems necessary or desirable and which are available for the fund. Moneys in the fund that are not needed to satisfy claims or meet the expenses and payments and obligations of the corporation may be invested in the manner provided by section 3-

31a, and all income from such investments shall become part of the Hospital Insurance Fund.

(b) In lieu of the procedures set forth in section 4a-20, the corporation shall procure or provide insurance coverage for the hospital against the liabilities described in subsection (a) of this section. The corporation shall procure such insurance coverages including coverage of related legal expenses which the corporation determines is necessary or desirable for the operations of the hospital. The corporation may cause sufficient amounts to be available in the Hospital Insurance Fund to self-insure against the liabilities which are charges against the Hospital Insurance Fund.

(c) The corporation shall designate the agent or agents of record and shall select the companies from whom insurance coverage shall be purchased. The corporation shall have full authority to negotiate all elements of insurance premiums, including the agent's commission. Any refund, dividend or other payment from any insurance company in connection with insurance for the hospital shall be deposited in the Hospital Insurance Fund. The corporation shall establish specifications for each contract of insurance and shall request bids for each such contract through the agent of record. Each such contract shall be for a specified period of time. The corporation shall purchase such insurance policies, develop and administer a self-insurance program, or any combination thereof, as will provide the insurance coverages or combinations thereof determined in accordance with subsection (b) of this section.

(d) The amount of money necessary to fund the amount that has been **[**actuarially**]** determined to be necessary to protect the hospital for the purposes for which the Hospital Insurance Fund was created, as determined and approved by the Board of Trustees of The University of Connecticut, shall be transferred to the Hospital Insurance Fund from the revolving fund of the hospital. Such determination shall not be subject to other review and shall be legally conclusive for purposes

of this section.

(e) **[**Any self-insurance program through the Hospital Insurance Fund shall be operated on an actuarially sound basis, and deposits shall be made to the fund as needed to comply with this policy.**]** If from time to time in the opinion of the corporation the addition of money to the fund is required to meet the obligations of the Hospital Insurance Fund as provided in sections 10a-250 to 10a-263, inclusive, the hospital shall upon written direction from the corporation provide sufficient funds to maintain the Hospital Insurance Fund **[**on an actuarially sound basis**]** at a level deemed necessary, that is exclusively determined and approved by the Board of Trustees of The University of Connecticut.

(f) The corporation may purchase such risk management, actuarial or other professional services as may be required to carry out the purposes of this section.

(g) The corporation and its subsidiaries shall be exempt from the provisions of chapter 368z, except those relating to certificates of need applications and capital expenditures, to the same extent as the hospital.

Sec. 61. Sections 19a-256, 19a-610, 19a-612a, 19a-612b, 19a-617c, 19a-695 and 19a-696 of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-612
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	19a-613
Sec. 4	*from passage*	19a-614
Sec. 5	*from passage*	19a-630
Sec. 6	*from passage*	19a-631
Sec. 7	*from passage*	19a-632(b)

Sec. 8	*from passage*	19a-634
Sec. 9	*from passage*	19a-638(b)
Sec. 10	*from passage*	19a-639
Sec. 11	*from passage*	19a-639b
Sec. 12	*from passage*	19a-639e
Sec. 13	*from passage*	19a-643
Sec. 14	*from passage*	19a-644
Sec. 15	*from passage*	19a-646
Sec. 16	*from passage*	19a-653
Sec. 17	*from passage*	19a-659
Sec. 18	*from passage*	19a-662
Sec. 19	*from passage*	19a-673a
Sec. 20	*from passage*	1-84(d)
Sec. 21	*from passage*	1-84b(c)
Sec. 22	*from passage*	1-101aa(a)
Sec. 23	*from passage*	4-5
Sec. 24	*from passage*	5-198
Sec. 25	*from passage*	17b-337(c)
Sec. 26	*from passage*	17b-353(a)
Sec. 27	*from passage*	19a-2b
Sec. 28	*from passage*	19a-7b(a)
Sec. 29	*from passage*	19a-7e
Sec. 30	*from passage*	19a-25e
Sec. 31	*from passage*	19a-123d(b)
Sec. 32	*from passage*	19a-127l(d)
Sec. 33	*from passage*	19a-486
Sec. 34	*from passage*	19a-486g
Sec. 35	*from passage*	19a-486h
Sec. 36	*from passage*	19a-498(d)
Sec. 37	*from passage*	38a-676a(c)
Sec. 38	*from passage*	38a-1051(e)
Sec. 39	*from passage*	19a-202a
Sec. 40	*from passage*	19a-202
Sec. 41	*from passage*	19a-245
Sec. 42	*from passage*	19a-694
Sec. 43	*from passage*	PA 09-148, Sec. 2
Sec. 44	*from passage*	17a-248g(e)
Sec. 45	*from passage*	38a-516a
Sec. 46	*from passage*	38a-490a
Sec. 47	*from passage*	New section

Sec. 48	*from passage*	New section
Sec. 49	*from passage*	54-203(b)
Sec. 50	*from passage*	New section
Sec. 51	*from passage*	19a-255
Sec. 52	*from passage*	54-102aa
Sec. 53	*from passage*	17b-492c
Sec. 54	*January 1, 2010*	54-56g
Sec. 55	*January 1, 2010*	54-56i
Sec. 56	*from passage*	New section
Sec. 57	*from passage*	New section
Sec. 58	*from passage*	New section
Sec. 59	*from passage*	PA 09-148, Sec. 3(b)
Sec. 60	*from passage*	10a-256
Sec. 61	*from passage*	Repealer section